



Sound Policy. Quality Care.

Statement for the Record

of the

Alliance of Specialty Medicine

before the

Ways and Means Subcommittee on Health U.S. House of Representatives

on the topic

“Programs That Reward Physicians Who Deliver High Quality and Efficient Care”

The Alliance of Specialty Medicine (Alliance), a coalition of 12 national medical specialty societies representing approximately 100,000 physicians and surgeons, would like to thank the Committee on Ways and Means, Subcommittee on Health for the opportunity to submit testimony for its February 7, 2012, hearing on “Programs That Reward Physicians Who Deliver High Quality and Efficient Care.” The Alliance is dedicated to advocacy for the development of sound federal health care policy that fosters patient access to the highest quality specialty care. To that end, the Alliance appreciates the Subcommittee’s consideration of innovative approaches to recognizing and rewarding physician quality and efficiency in its search for a long-term solution to the Medicare physician payment system. Many of these medical specialty societies have a physician-driven national quality improvement initiative based on national registries with clinically-relevant performance measures developed from evidence-based guidelines. While more work remains, these physician-driven initiatives provide a unified approach to benchmark specialty practices and provide relevant feedback to physicians on how their performance compares with the national standard. Nevertheless, the Alliance remains deeply concerned that many payer-led quality improvement efforts are misaligned with physician-driven quality initiatives, lack sufficient flexibility to accommodate different specialties and care settings, rely on measures that are inadequately risk adjusted and not necessarily linked to better patient outcomes, and divert significant resources away from direct patient care.

As you already know, unless Congress acts, the flawed SGR formula will continue to slash physician payments by more than 40 percent over the next decade, despite the fact that Medicare reimbursement rates are already well below market rates. Deep cuts jeopardize the viability of many physicians’ businesses and imperil Medicare beneficiaries’ access to specialty care. The Alliance supports replacing Medicare’s SGR formula with a stable mechanism for updating Medicare fees that adheres to the following principles:

- **Ensures that all physicians receive adequate reimbursement.** Physician shortages are looming in many specialties, not just primary care, and any payment differentials will further exacerbate significant shortages of specialty physicians.
- **Recognizes reasonable inflationary medical costs** such as the Medicare Economic Index (MEI).
- **Allows Medicare beneficiaries access to the physician of their choice.** Patients and physicians should be able to freely contract for Medicare covered services without having to lose their Medicare benefits.
- **Maintains a fee-for-service option.** As other payment systems are explored for both Medicare and the private sector, it is important that both public and private payers maintain a fee-for-service option, as this may work best for some physicians and their patients, especially those with serious illness or in underserved areas where provider choice is already limited. The key is not eliminating fee-for-service, but rather identifying where this option makes the most sense.
- **Provides an appropriate timetable and required investment for reforms.** New payment systems, including those targeting quality and efficiency, need appropriate time for proper implementation, as well as investment in key infrastructure.
- **Aims to improve quality and efficiency** through flexible strategies that are evidence-based, meaningful and appropriate for a range of patient populations and care settings, feasible, and non-punitive.

Given the emphasis of this hearing, the sections below will focus on those elements critical to ensuring successful implementation of efforts to improve physician quality and efficiency.

Measurement Development and Selection

Many measures widely used in public and private payer recognition programs are of questionable value and are not necessarily valid indicators of quality or value. For example, a study recently

published in the Archives of Internal Medicine¹ linked higher patient satisfaction scores with greater healthcare costs and increased risk of mortality, suggesting a tenuous link between patient satisfaction and healthcare quality and outcomes. Using data from more than 50,000 patients, the study found that those who reported the most satisfaction with their care had a 26 percent higher mortality risk, after adjusting for health status, sociodemographics, insurance status, and other factors. Those patients also had higher overall healthcare expenditures, higher drug expenditures and higher inpatient admissions. Despite the growing reliance on satisfaction scores as a tool for evaluating physician performance, efforts to satisfy patients may have downsides that lead to unnecessary care and risks without the benefits.

To ensure that measures are meaningful to consumers and reflect a variety of clinical encounters, quality improvement programs should employ a combination of measures, including 1) process-of-care measures for which evidence shows that better performance leads to better outcomes, 2) measures that evaluate outcomes directly, and 3) structural measures that encourage the use of technology and other infrastructure to improve quality and efficiency. This multi-pronged approach helps minimize the pitfalls of relying solely on process-of-care measures, which are not always relevant to all specialties and can encourage gaming, or solely on outcomes measures, which may be difficult to achieve and beyond the control of physicians. The Alliance recommends that a physician-driven, unified approach to quality improvement is the best approach to determine the combination of measures that will reduce variation in care and provide clinically-relevant feedback to physicians.

The Alliance asks that both the public and private sector give careful consideration to the development of cost of care measures-- an undeveloped area of measure development that is in its infancy. Payers continue to struggle with how to accurately define and measure appropriate resource utilization in health care and very few trustworthy mechanisms currently exist. In fact, the RAND Corporation recently issued a series of studies that questioned the reliability of cost profiling.^{2 3} One study found that physician ratings based on cost of care can be incorrect up to two-thirds of the time for some physician specialties while misclassifying one-fourth of all physicians under the *best-case* scenario used by most health insurers. The authors ultimately concluded that "current methods of physician cost profiling are not ready for prime time" and that "current cost profiling approaches need to be improved, or new approaches need to be developed." The Alliance recommends that physician performance not be linked to cost of care measures until further study and refinement occur.

Measures that evaluate spending must be evidence-based and must be primarily aimed at improving the quality of patient care, rather than achieving monetary savings. The practice of medicine cannot be judged on cost alone, especially since improvements in care often require the expenditure of resources and may lead to increased spending. A 2009 study, for example, underscored how difficult it can be to predict when additional treatments – and, thus, spending – will benefit a particular patient and suggested that there are instances in health care when more spending can actually save lives.⁴

The Alliance also recommends that payers carefully consider the limitations of using procedure volume as an indicator of quality or efficiency, especially for complex, heterogeneous aspects of specialty care.^{5 6 7} Since high volume is not always associated with superior outcomes, this

¹ Fenton, J., et al. **The Cost of Satisfaction.** Arch Intern Med. Published online February 13, 2012, at <http://archinte.ama-assn.org/cgi/content/abstract/archinternmed.2011.1662v1>

² Adams, J., et al. Physician Cost Profiling — Reliability and Risk of Misclassification. N Engl J Med 2010; 362:1014-21.

³ Mehrotra, A., et al. The Effect of Different Attribution Rules on Individual Physician Cost Profiles. *Ann Intern Med.* 2010; 152:649-654.

⁴ Ong, M., et al. Looking Forward, Looking Back: Assessing Variations in Hospital Resource Use and Outcomes for Elderly Patients with Heart Failure. *Circulation: Cardiovascular Quality and Outcomes.* Published online October 13, 2009 at <http://circoutcomes.ahajournals.org/content/early/2009/10/13/CIRCOUTCOMES.108.825612.short>

⁵ Daley J. Quality of care and the volume-outcome relationship— what's next for surgery? *Surgery* 2002;131:16-8.

⁶ Sheikh K. Reliability of provider volume and outcome associations for healthcare policy. *Med Care* 2003;41:1111-7.

⁷ Heros RC: Editorial: Case volume and outcome. *J Neurosurg* 99: 945-946, 2003.

information should only be used in confidential feedback reports to physicians and not in reports released to the public.

While measures should be developed through a consensus process that includes all relevant stakeholders, physician involvement in the development and testing of measures is critical and the only way to ensure measures are valid *and* clinically appropriate. Process and outcomes measures should be based on the highest levels of evidence available, but should also take into account importance and feasibility to collect and report data. Overall, the Alliance recommends that measures should be clinically-relevant to improve patient care, and not simply adhered to for the sake of reporting or to comply with a poorly developed quality initiative.

Measures should be carefully developed to take into account differences in patient health and patient compliance with treatment. The importance of risk adjustment cannot be overstated, especially when payment is tied directly to physician performance. If the measurement specification is not accurately adjusted, physicians who provide compassionate treatment to more complicated or riskier patients-- such as those with multiple chronic conditions-- will suffer the unintended consequence of performing below the national standard and may try to avoid such patients in need, creating serious access to care issues. Risk adjustment is equally important for measures of cost as it is for measures of quality. The Center for Studying Health System Change recently studied regional spending variation using autoworkers' health claims and found that the biggest contributor to higher regional spending was patient case mix.⁸ Poorer health status of patients contributed the most to spending, not unnecessary utilization of services or higher prices charged by physicians. Given the continued paucity of trustworthy tools, the Alliance recommends that public and private payers devote additional resources to the development of improved risk adjustment and attribution methodologies.

Participation in all quality improvement programs must be voluntary, and physicians should have the opportunity to select measures relevant to their patients and practice. Even physician-driven quality programs recognize that the local capacity to implement quality into the practice will be incremental in order to assure unintended disruption in patient care. Furthermore, sponsors of quality improvement programs should work collaboratively to align and harmonize measures, which will promote consistency and limit the overall cost and burden of collecting data from physicians.

Flexibility In Quality Improvement Approaches

There is currently little empirical evidence supporting the superiority of one quality improvement strategy over the other. In most cases, the optimal model will depend on the clinical context. We also have learned from Medicare's Physician Quality Reporting System (PQRS) and other public and private initiatives that one size does not fit all when measuring quality. For example, what may be a useful indicator of quality of care for a primary care physician may reveal little about the quality of care provided by a specialist. The long-term potential of public and private payer initiatives to close quality gaps and achieve better value lies in the ability to accommodate multiple aligned quality improvement strategies rather than any singular approach.

Much of Medicare's current physician quality improvement efforts focus on strategies that are primarily targeted toward primary care and chronic disease management. Many of these efforts rely on a long list of evidence-based process-of-care measures to evaluate physician quality. While these process measures can be readily acted upon and may be important in some clinical settings, they are not necessarily consistent with clinical outcomes and say very little about the quality of specialty care. In fact, various studies have shown that incentivizing the reporting of process measures often only

⁸ White, C. Health Status and Hospital Prices Key to Regional Variation in Private Health Care Spending. Center for Studying Health System Change. 2012.

produces improvements in documentation rather than a change in the quality of health care delivered to patients.^{9 10 11}

To ensure that quality improvement initiatives are actionable and meaningful for a range of patients and physicians, the Alliance recommends that public and private payers must offer flexibility in terms of measures and reporting options.

Recognizing the Value of Clinical Data Registries

Claims data is an inaccurate surrogate for determining the quality of care. Medicare's current physician quality improvement efforts also rely heavily on claims data. While claims data are easy to collect, the claims system was developed for billing purposes only and not for quality measurement. There is no nationally accredited certification that assures that layman professionals are qualified and adequately trained to collect accurate claims data for purposes of reporting quality data. As a result, claims data are limited in clinical scope and rife with inaccuracies and attribution errors. These errors can result from limitations of the claims system itself, from inappropriate/incomplete coding, and even from health plan reimbursement policies. For example, capitated payments make it difficult to identify when visits actually occurred and what services were delivered, bundled services do not allow for the identification of separate services, and "carved-out" services often hide data necessary for quality measurement.

The Alliance believes that observational data submitted to a registry is more clinically relevant and more accurate than the current claims reporting system. Although clinical trial data offers the strongest evidence-base, it is extremely expensive, lengthy to conduct, and vulnerable to other challenges such as maintaining clinical equipoise. Therefore, the Alliance strongly encourages public and private payers to recognize the value of observational data by aligning their quality programs to incentivize physician use of registries (i.e., to off-set the on-going costs to implement and maintain a registry). Registries are a well-recognized quality improvement tool to collect and provide feedback to physicians on their performance relative to a national standard. They are designed to identify, monitor, and compare differences in processes and outcomes within and among communities. When a difference is established, a registry can undertake subsequent analyses to identify factors that may or may not be associated with that difference. Since registries are ongoing, physicians have the tools to monitor changing practice patterns and the impact of those patterns on patient outcomes. Registries also allow for more accurate attribution and the capturing of more detailed data than claims-based systems, including patient-reported outcomes. The information provided by registries helps to guide physician treatment decisions and has been known to change practice in a beneficial manner.

Several of member organizations of the Alliance have developed or are participating in specialty specific clinical registries. Examples of these registries include:

- NCDR[®] CARE Registry[®] (The Society for Cardiovascular Angiography and Interventions, the American Association of Neurological Surgeons, and the Congress of Neurological Surgeons with the American College of Cardiology): For carotid artery revascularization and endarterectomy procedures. This registry provides: (1) A "best practices showcase" for all disciplines involved in treating carotid artery disease — cardiology, neurology, radiology, vascular surgery, neurosurgery, and interventional neuroradiology; (2) benchmarked decision-

⁹ Roski J, Jeddloh R, An L, Lando H, Hannan P, Hall C, et al. The impact of financial incentives and a patient registry on preventive care quality: increasing provider adherence to evidence-based smoking cessation practice guidelines. *Prev Med.* 2003;36:291-9. [PMID: 12634020].

¹⁰ Fairbrother G, Hanson KL, Friedman S, Butts GC. The impact of physician bonuses, enhanced fees, and feedback on childhood immunization coverage rates. *Am J Public Health.* 1999;89:171-5. [PMID: 9949744].

¹¹ Fairbrother G, Siegel MJ, Friedman S, Kory PD, Butts GC. Impact of financial incentives on documented immunization rates in the inner city: results of a randomized controlled trial. *Ambul Pediatr.* 2001;1:206-12. [PMID: 11888402].

making data to answer critical questions on quality assurance related to high-risk new technologies; and (3) independent neurological assessment, including NIH Stroke Scale scores before, immediately after, and at 30 days post-procedure, to support treatment choices.

- NCDR® [CathPCI Registry®](#) (The Society for Cardiovascular Angiography and Interventions with the American College of Cardiology): For diagnostic cardiac catheterizations and percutaneous coronary interventions. The CathPCI Registry offers: (1) risk-adjusted benchmark reports containing practice patterns, demographics, and outcomes of diagnostic procedures and therapies showing the facility, comparable facilities, and the national comparison group data; and (2) an unique view of guidelines in practice, PCI records tracking pharmaceutical and device safety, plus research findings from peer-reviewed journal articles and abstracts.
- NCDR® [ICD Registry™](#) (Heart Rhythm Society with the American College of Cardiology): For implantable cardioverter defibrillators and leads. The ICD Registry is able to: capture atrial, ventricular, defibrillator, and left-heart lead data at time of implant, revision, replacement, or surgical abandonment; monitor and report pediatric ICD implantation data to expand the knowledge base for an important patient population with unique needs at implantation; ICD/CRT-D generators for primary and secondary prevention and update key quality indicators and align its data set more closely with current guidelines.
- NCDR® [IMPACT Registry™](#) (The Society for Cardiovascular Angiography and Interventions with the American College of Cardiology): Assesses the prevalence, demographics, management and outcomes of pediatric and adult patients with congenital heart disease who are undergoing diagnostic catheterizations and catheter-based interventions.
- Ophthalmic Patient Outcomes Database (The American Society of Cataract and Refractive Surgery with the American Academy of Ophthalmology): A CMS-certified registry that allows providers to submit data to CMS' Physician Quality Reporting System (PQRS). This registry also includes benchmark reporting capabilities allowing physicians to compare their practices with their peers.
- Digestive Health Outcomes Registry™ (American Gastroenterological Association): Aims to improve patient health outcomes and cost effectiveness of digestive care using scientifically valid methods to collect, analyze and report clinically relevant data, empowering the health-care community to optimize quality of care. The AGA Registry is a CMS-certified registry, enabling practices to submit data for PQRS. It also captures and provides feedback to gastroenterology practices regarding the quality of their colorectal cancer prevention care, as well as the care of patients with inflammatory bowel disease and hepatitis C. Quality can be assessed at the clinician level, across all practice settings. The overall goal is to optimize the care and outcomes of digestive health conditions by: implementing evidence-based guideline recommendations in clinical practice; assuring that the right things are done for the right patient at the right time in a safe manner; and support efforts to improve digestive healthcare, quality, and safety through novel quality improvement strategies. In the summer of 2012, the AGA will launch the Digestive Health Recognition Program (DHRP), which will enable clinicians to be recognized by the AGA and/or rewarded by health plans for meeting quality thresholds.
- NeuroPoint Alliance (NPA) (The American Association of Neurological Surgeons/Congress of Neurological Surgeons): An effort to coordinate a variety of national projects involving the acquisition, analysis and reporting of clinical data from neurosurgical practice, using a web-based data submission and management platform. The NPA aims to satisfy practice data collection requirements for board certification and Maintenance of Certification (MOC), establish risk-adjusted national benchmarks for both the cost and quality of common neurosurgical procedures, allow practice groups and hospitals to analyze their individual morbidity and clinical outcomes in real-time, generate both quality and efficiency data to support claims made to public and private payers, and demonstrate the comparative effectiveness of neurosurgical procedures. The National Neurosurgery Quality and Outcomes Database (N2QOD), which launched last year, is a targeted effort to collect site-specific, risk-

adjusted quality data related to spine surgery, including patient-reported outcomes. The N2QOD will analyze practice variations and utilization in an effort to demonstrate the value of neurosurgical care.

To ensure these registries can reach their fullest potential, the Alliance encourages both the public and private sector to support programs that incentivize continuous and prospective participation in a clinical data registry and the use of collected data to improve care processes. While national specialty societies or other stakeholders would be responsible for the development, validation, and management of registries, CMS and other private payers could set minimum requirements for registries to qualify for incentive payments. A registry may need to demonstrate it employs a valid risk adjustment methodology; may need to collect data on specific outcomes such as complications and recovery time; may be subject to sample size requirements; or may be required to use standardized clinical definitions to ensure uniformity with other registries. Furthermore, payers could require physicians to demonstrate what actions were taken to target gaps in care identified by the registry.

The Alliance is confident that up-front investment through incentives to offset the cost of registry participation will have a positive impact on reducing morbidity, mortality, and the costs associated with complications, as well as the potential for decreased volume and efficiency over time as physicians reflect on collected data, refine care processes that lead to better outcomes, and more clearly define indications for various procedures.

Various private payers have approached specialty societies with interest in incentivizing the use of registries. Some, such as the Blue Cross Blue Shield Blue Distinction Program, already recognize registry reporting as one of various factors that defines a center of excellence. This illustrates private payer confidence in the value of continuous clinical data collection as a driver of rapid learning about both quality and efficiency. It also stands as a testament to their understanding that alternative, more targeted strategies are necessary to better effect improvements in specialty quality.

Public Reporting of Physician Data

While public reporting may stimulate more rapid improvement among those being measured and may make patients more informed decision-makers, it also carries risks. If data are released prematurely or in a format that is not accurate, it can increase a physician's exposure to medical liability, lead to perverse incentives such as gaming or other actions to avoid high-risk patients, and deter physicians from partaking in quality improvement activities in general. Furthermore, if data are not adjusted properly and not presented in a format that is meaningful and comprehensible to a range of audiences, it may create confusion among patients and unfairly harm the reputation of a physician.

Medicare's first public effort to identify hospitals with patient safety problems recently pinpointed many prestigious teaching institutions around the nation, raising concerns that the measures are skewed in a way that exaggerates problems at hospitals that treat lots of complicated cases or very sick patients.¹² Hospital performance on these patient safety measures is already being reported to the public and Medicare payments to hospitals will be tied to the measures starting in 2013, despite the fact that the National Quality Forum (NQF) recommended against using the measures for payment due to concerns about the reliability of the data sources. Critics claim the measures are not properly risk-adjusted and based on Medicare claims data, which do not properly distinguish between various levels of illness and health problems among patients. Others say the measures were never intended to compare hospitals, but were developed to help hospitals internally flag events that needed attention. Either way, the public reporting of inaccurate information may confuse the public and divert patients from experienced centers of care.

¹² Rau, J. Experts Question Medicare's Effort To Rate Hospitals' Patient Safety Records. Kaiser Health News. February 13, 2012.

It is imperative that public and private payers adhere to the following principles if reporting physician quality and cost data to the public:

- Physicians should be provided with confidential, user-friendly interim feedback reports so that they can understand their progress, better target areas of improvement, and flag any discrepancies between their records and that of the measurer;
- The Alliance cannot overstate the importance of appropriately risk-adjusting data and ensuring that it is accurately attributed to those directly involved in the care of the patient prior to it being released to the public;
- Data must be presented in a way that is both meaningful and understandable to physicians and the public. Public reports should include clear discussions of context, the measures and methodologies used (e.g., how were episodes defined, how were patients identified, why were certain units of analysis used), data limitations, and guidance on how to use the data when seeking medical care (e.g., talk with your physician). Medicare's Nursing Home Compare website currently includes valuable information for consumers on how to use the comparative reports, including telling consumers that information on the web is not a substitute for visiting a nursing home in person;
- Physicians should be offered a formal and timely process to review, question, or appeal performance and other data (e.g., demographic, volume, resource use) that they believe to be inaccurate before it is publicly reported or linked to reimbursement. Results determined to be inaccurate after the reconsideration process should be corrected. As an example, data posted on Medicare's Hospital Compare website are externally validated and hospitals are given an opportunity to review their own data prior to reporting; and
- Physicians should have an opportunity to explain to the public, alongside the reported data, why they may have chosen not to participate in or failed to meet the requirements of a program. Public reports should positively recognize, not punish or shame, physicians who attempted to participate, but were unable to do so for a variety of reasonable obstacles. Physicians also should be recognized for a range of quality initiatives, including those sponsored by CMS, private health plans, employers, individual specialty societies and their local institutions or practices. A "one-size-fits-all" approach to quality improvement is simply not sustainable.

Incentives

Incentive payments for achieving the goals of improved quality and efficiency should be provided in addition to annual positive increases in the Medicare physician payment update that accurately reflect increases in medical practice costs. Only fair, meaningful, and *positive* incentive structures will encourage positive change. Incentives must be large enough to change behavior and aligned to processes of care that are actionable by a physician.

As discussed earlier, public and private payers should continue to broaden the scope of quality improvement activities that qualify a physician for an incentive payment. Incentives should be offered for a range of efforts, such as reporting to a clinical data registry, maintaining medical board certification, using e-prescribing technology, and reporting on a designated set of process/outcome measures. Rather than making each of these activities mandatory, physicians should be able to choose to participate in those programs that are most relevant to their practice. A graduated incentive structure could be used to recognize the additional time and resources required to participate in more complex quality improvement activities.

Physicians must also receive incentive payments on a timely basis. Payments should be made as close as possible to the time that the service is rendered, without a substantial time lag in determining the amount of payment due to a physician. A physician practice, like any other enterprise, must operate on a business plan based on predictable and reliable financial fundamentals. This is nearly

impossible if a substantial amount of a practice's revenue stream is unknown and delayed for months or even years.

Payers should also explore a mix of incentive structures, such as rewarding physicians who achieve significant improvements in their absolute performance (i.e., overall improvement), as well as those who achieve high performance (i.e., achievement of a minimum threshold). Studies have shown that those with the lowest baseline performance may improve the most, yet garner the smallest amount of performance pay if only threshold performance targets are used,^{13 14} highlighting the need to consider a mix of incentives. Payments should not be based on relative performance or arbitrary assignment of physicians to a percentile. These structures would only be fair in a perfect world where all physicians and patients were exactly alike. Since it is impossible to adjust for all patient case-mix and other confounding factors and difficult for individual physicians to gauge their performance relative to others throughout the year, these structures should be avoided.

Redundancies in Quality Programs

Each medical specialty society is dedicated to improving the quality and overall efficiency of the care of their patients. However, we are highly concerned about inconsistencies in requirements for various quality-related reporting programs-- including Medicare's Electronic Prescribing (eRx) Program, Electronic Health Records (EHR) Program, and Physician Quality Reporting System (PQRS). The inconsistent and duplicative reporting requirements of these and other public and private payer programs create confusion among physicians and their patients and are incongruous with the goals of improving the quality, efficiency, and coordination of care. In 2011, the Government Accountability Office (GAO) issued a report¹⁵ calling on CMS to address these inconsistencies. Considering the hard economic times and the fact that physicians already face the threat of substantial cuts through the SGR, it is simply unreasonable and unfair to expect physicians to be able to provide high quality, patient-focused care while also having to contend with these cumbersome reporting requirements. As noted throughout our comments, requirements imposed in the name of advancing quality should be reasonable, should not distract from care delivery, and should be relevant to all affected professionals. We urge Congress to work to better align the various, overlapping quality incentive programs in order to minimize confusion and prevent the imposition of unjustified financial and administrative burdens on physician practices.

While each of our societies is taking steps to improve quality measurement tools and encourage participation in such programs, physicians will need time to acclimate to these new programs and to modify clinical and administrative processes to accommodate these new care models. Public and private payers should not rush physicians into new delivery system models until they have been fully tested among a range of specialties and patient populations and until an appropriate infrastructure exists to support consistent and long-term application of these new models. Careful implementation includes ensuring patients can maintain access to current care options as new payment and delivery models are being tested.

¹³ Rosenthal MB, Frank RG, Li Z, Epstein AM. Early experience with pay-for-performance: from concept to practice. *JAMA*. 2005;294:1788-93.

¹⁴ Pourat N, Rice T, Tai-Seale M, Bolan G, Nihalani J. Association between physician compensation methods and delivery of guideline-concordant STD care: is there a link? *Am J Manag Care*. 2005;11:426-32.

¹⁵ U.S. Government Accountability Office. *Electronic Prescribing: CMS Should Address Inconsistencies in Its Two Incentive Programs That Encourage the Use of Health Information Technology*. Published online February 2011 at <http://www.gao.gov/new.items/d11159.pdf>

Conclusion

Although the Alliance understands the desire to measure and improve both the quality and efficiency of health care, programs that rely on inaccurate ratings to steer patients to select physicians and to alter physician reimbursement will only restrict patient access to the high value care they deserve. More time and resources are needed to test valid measures of cost and quality and mechanisms that adjust for more complex clinical scenarios before the public and private sector can move forward with programs that further tie physician payments to performance. More flexibility is also needed so that physicians are recognized for engaging in quality improvement processes that are most relevant to their patient population and care setting.

The Alliance appreciates the opportunity to share its concerns with members of the Ways and Means Committee, Subcommittee on Health, and to point out the unique needs and contributions of specialty medicine. Should you or your colleagues have any questions or want to discuss in further detail the issues raised in this letter, please feel free to contact Rachel Groman at 202-729-9979 or info@specialtydocs.org.