Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

December 16, 2008

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

File Code: CMS-1421-N

RE: Comments on Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services

Dear Mr. Weems:

The 20 undersigned organizations representing consumer, labor and purchaser interests wholeheartedly support the Centers for Medicare & Medicaid Services (CMS) in its effort to meet Congress' direction to align Medicare's payment policy and practices to encourage ongoing improvements in the quality and efficiency of care delivered by physicians and other professionals. Our current payment system does not reward better care; moving forward, it is essential that payment provide the right incentives to providers to ensure the delivery of appropriate, high-quality, efficient, equitable, and patient-centered care. Medicare and Congress are demonstrating strong leadership in reforming health care by continuing to actively pursue value-based purchasing across multiple sectors.

We strongly support the goals, objectives, and assumptions outlined in the Issue Paper. We would also add the general design principle that CMS not only learn from other initiatives in value-based purchasing, but seek to actively coordinate and align with private sector initiatives. CMS can and should not do this alone. In terms of prioritizing areas to be addressed by the program, CMS should look to the National Priority Partners for direction. The Partners have identified a set of National Priorities and Goals to help focus performance improvement efforts on high-leverage areas. These areas include: engaging patients and families, improving health, improving safety, ensuring well-coordinated care, guaranteeing appropriate and compassionate end-of-life care, and eliminating overuse.

We recognize that a "one size fits all approach" to implementing a Medicare value-based purchasing program for physician and other professional services will limit getting the maximum benefit for this initiative. We support having multiple tracks that all strive in achieving the goal of encouraging higher quality, more efficient professional services.

C/O National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650
Washington, DC 20009
202.986.2600 • 202.986.2539 (fax) • healthcaredisclosure.org

In addition to the examples listed in the Issues Paper, we also recommend CMS considers “tracks” that both improve quality and generate savings, such as potentially preventable complications and overuse of services. Not only is there a quality benefit, but the savings could be used to help fund the financial incentives for the program.

We want to commend CMS’ attention to the issue of health care disparities in the overarching design of the program. Any program directed at improving care should ensure that it does not unintentionally create a greater gap in quality of care between those that are advantaged and those that are not. CMS should develop an evaluation plan that includes monitoring the impact of the program on health care disparities. A key component to the evaluation should be comparing results of physicians that serve traditionally disadvantaged patients with other physicians.

The remainder of our document is organized in the four sections around which the CMS is soliciting comments. For convenience, we have highlighted some major messages in bullets at the beginning of the section.

Measures:

- The Federal Government must support the development and endorsement of a robust set of physician and other professionals’ performance measures.
- Outcome measures are very much needed. While we affirm the use of both structural and process measures, we need to move towards relying more on measures of outcomes.
- CMS should make patient experience a core element of this program and launch the Clinician/Group CAHPS survey.
- Over-reliance on measures that reflect only minimum standards of competence will “clog” the system and divert from resources that should be allocated to measures that are far more meaningful to consumers and purchasers. Measures should not allow physicians to receive rewards for providing marginally effective care or care that should already be routinely furnished.
- When it is feasible, measurement of and accountability for quality and efficiency of care must include, but not be limited to, individual doctors, in addition to higher levels of aggregation.

The Federal Government must support the development and endorsement of a robust set of physician and other professionals’ performance measures. Measures need to address all of the IOM’s six aims (safe, timely, effective, efficient, equitable, patient-centered), and in particular there is a need for measures on care coordination, equity, disparities, and functional health. Included in the mix should be measures that are cross-cutting and apply to all professions as well as those appropriate for particular specialties. Additionally, measures being developed should address the four evaluation criteria used by the National Quality Forum (NQF): importance, scientific acceptability, feasibility, and usability. While we affirm the use of both structural and process measures, we need to move towards relying more on measures of outcomes. While more outcome measures very much need to be developed, there are some currently available outcomes measures that can help fill the gap, such as those of the National Surgical Quality Improvement Program.

We are concerned that over-reliance on measures that reflect only minimum standards of competence will "clog" the system and divert from resources that should be allocated to measures that are far more meaningful to consumers and purchasers. Measures should not allow physicians to receive rewards for providing marginally effective care or care that should already be routinely furnished. Measures based on this type of care could diminish the overall effectiveness of the quality reporting initiative, and eventually could work at cross-purposes to Medicare's efforts to increase quality, as well as efficiency, of physician services delivered to beneficiaries.

The measure development process cannot meet patient, clinician or system needs if it operates in silos. CMS should foster the rapid and robust development of measures that cut across conditions, settings and clinicians. CMS should also help facilitate the harmonization of measures that are already developed.

CMS should make patient experience a core element of this program and launch the Clinician/Group CAHPS survey. In California, over 3,000 primary and specialty care physicians are being assessed based on patient-level standardized surveys. Massachusetts has also demonstrated in the commercial and Medicaid populations that it is possible to obtain reliable and valid measures of patient experience on primary care physicians.

We support the inclusion of episodes of care in the value-based purchasing program. CMS should consider the work done by MedPAC, Bridges to Excellence, and others to help guide their inclusion.

Physician accountability and attribution are key elements in measuring quality and efficiency in the healthcare sector. Physicians are the primary suppliers of care throughout the healthcare sector - they prescribe medications, initiate diagnostic studies, authorize hospital admissions, and, for many patients, are the entry point to engaging other specialists. It is the physician to whom patients and families look and in whom they place their trust, health and lives. Patients see their doctor as their key adviser for most matters relating to their health care. Patients trust and expect their physicians to take accountability for the system they engage on their behalf. As a general rule, when it is feasible, measurement of and accountability for quality and efficiency of care must include, but not be limited to, individual doctors, in addition to higher levels of aggregation. Reporting at higher levels of aggregation will mask the variation in quality and efficiency that occurs at the individual doctor level. Additionally, when selecting physicians consumers look for information on the individual and not group to inform their choice.

Incentives:

- The share of payment tied to performance should be substantial. The overall proportion of CMS payments to physicians that are directly linked to performance should increase as the program matures.
- Incentives should be based on a combination of improvement and meeting performance thresholds.
- We support a shift in "valuing" of payment to consider the value to patients of primary care and care coordination.

Incentives should support the evolution of the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. We enthusiastically support the Centers for Medicare & Medicaid Services moving from pay for reporting to paying for the right care at the right time for physicians and other professionals.

We also recognize that changes need to foster a reimbursement system that:

- Supports shift in "valuing" of payment to consider the value to patients of primary care and care coordination.
- Encourages the integration and delivery of services for those with chronic illnesses such as a medical home, broader use of nurses and team-based care, and revaluing on budget neutral basis to increase payment for primary care.
- Drives rapid re-engineering of care delivery, such as those that are IT-enabled.
- Reduces health care disparities and encourages the provision of quality care for at-risk populations.
- Recognizes efficient and effective care may reduce expenditures both within a single sector and between sectors. For example, physician services may reduce expenditures in emergency rooms and hospital care. Episode or bundled care should be implemented.
- If not fostering a reduction in total spending, payments should be budget neutral.

One way that even the current payment reforms could drive toward a health care system that accomplishes the above goals is to have a disproportionate share of incentives made available for care delivery that promotes these goals (rather than having all types of care have the same potential rewards for "better" performance).

The share of payment tied to performance should be substantial. The overall proportion of CMS payments to physicians that are directly linked to performance should increase as the program matures. CMS should set and revise the appropriate level using the information that continues to develop from its implementation of performance-based payments for eligible professionals, hospitals, demonstration projects, and from private sector efforts. We also strongly support performance incentives being budget neutral. Providing additional funding to finance performance incentives is an unrealistic option given the current economic environment.

CMS should be flexible in incorporating different methods for the incentive structure to achieve specific goals and accommodate different practice arrangements. For example, avoiding complications may have an incentive that shares the savings between CMS and providers while another arrangement may be a bonus "pool" structured to differentially reward primary care instead of an "across the board" percentage applied to all physicians.

We concur with the Institute of Medicine's (IOM) *Rewarding Provider Performance* report that recommends incentives should be based on a combination of improvement and meeting performance thresholds. As Medicare moves to institutionalize performance-based payment, it should consider how to use baseline thresholds of performance and the potential of relative comparisons to encourage and foster action by all physicians to make improvements appropriate to their current level of performance.

Data:

- As a first priority, measures should be derived from currently available electronic data that does not require additional coding by physicians.
- CMS should continue to proactively pursue the submission of data via other electronic means, including electronic health records.
- CMS should make physician-identifiable data available for merging with that of other payers to create "all payer" data so as to provide the best possible picture of providers' care.

Data collection is a key component to performance measurement and public reporting. CMS should strive for a data collection process that imposes a minimum burden on physicians. As a first priority, measures should be derived from currently available electronic data that does not require additional coding by physicians. With administrative data, Medicare can evaluate the performance of each health care provider that bills Medicare, using nationally-endorsed, scientifically-valid, risk-adjusted, and regularly-updated measures. CMS also must continue to proactively pursue the submission of data via other electronic means, including electronic health records. Advances in the electronic health record have the potential to have major positive impacts. For example, the electronic health record (EHR) can support clinical decision-making where and when it is needed. A supplemental benefit is using the data to support other activities, such as performance measurement. The burden of data collection is reduced since it is tied to the point-of-care and serves multiple purposes. Moreover, access to the information is real-time. To improve obtaining performance information through electronic health records, CMS should join efforts to identify strategies to reduce or eliminate duplicative algorithm programming by multiple vendors through the use of common codes. When electronic data collection is not feasible for a measure, there should be a clearly articulated and credible path for future electronic submission.

CMS should allow other organizations to have full access to physician and other professionals' performance information. CMS should immediately make available physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting now. Additionally, CMS should use other public and private sector data in its initiative whenever possible. This will help harmonize efforts and help address some technical issues associated with reporting information on individual physicians.

We strongly encourage CMS to explore capturing information that identifies the physician responsible for referrals or ordering. Also, CMS should require lab results as a condition for payment. Using this data will greatly advance performance measurement.

Ensuring the accuracy and completeness of data is absolutely critical so that all stakeholders believe in the credibility of the information, given its increasing relevance in the marketplace. CMS should use lessons learned from PQRI, BQI, and other physician-reporting initiatives to inform the development of an auditing program. The methodology adopted should be fully transparent to allow all stakeholders to clearly assess the reliability.

Public Reporting:

- CMS should put more effort into making the data useable for other organizations to utilize in their respective performance reporting programs than it does to display on its own website.

The scoring and the display of performance information should be made, first and foremost, with consumer decision-making in mind. We support CMS in its efforts to ensure that performance information is accessible and useful by the consumer. To that end, CMS should allow other organizations to have full access to physician and other professionals' performance information. The public reporting of physician and other professionals' performance information for the entire US is a laudable goal but nevertheless a huge undertaking, to say the least. CMS should partner with other organizations that are involved with developing performance reports for communities. Given the limited resources that will be dedicated to implementing a value-based purchasing program for physicians and other professionals, CMS should put more effort into making the data useable for other organizations to utilize in their respective performance reporting programs than it does to display on its own website. Additionally, this will support all-payer data initiatives and help address some technical issues associated with reporting information on individual physicians.

Finally, we would like to call your attention to the Disclosure Project's "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs" (http://healthcaredisclosure.org/activities/charter/) which details strict terms that sponsors of physician reporting programs must meet. The agreed upon criteria are supported by a wide variety of stakeholders including consumers, purchasers, physician organizations, and health plans.

We appreciate your consideration of our suggestions and look forward to working with you on further development of a plan to transition to a Medicare value-based purchasing program for physician and other professional services.

Sincerely,

American Hospice Foundation
Bridges To Excellence
Center for Medical Consumers
Childbirth Connection
Consumers Union
Employer Health Care Alliance
General Electric Company
Group Insurance Commission, Commonwealth of Massachusetts
Hanover Area Health Care Alliance
Health Policy Corporation of Iowa
HEREIU Welfare Fund
Intel
Iowa Health Buyers Alliance
National Business Group on Health
National Partnership for Women & Families
National Retail Federation
Pacific Business Group on Health
Puget Sound Health Alliance
The Alliance
The Leapfrog Group