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

May 15, 2009

The Honorable Max Baucus
Chairman
Senate Finance Committee
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Senate Finance Committee
Washington, DC 20510

Re: Comments on Senate Finance Committee Policy Options for Transforming the Health Care Delivery System

Dear Senators Baucus and Grassley:

The Consumer-Purchaser Disclosure Project, a collaboration of leading consumer, labor and purchaser organizations, wholeheartedly supports the Senate Finance Committee's proposed policies that move the nation in the direction of aligning payment policies and practices to encourage ongoing improvements in the quality and efficiency of care delivered by Medicare providers. Our current payment system does not reward better care; moving forward, it is essential that payment provide the right incentives to providers to foster the delivery of appropriate, high-quality, efficient, equitable, and patient-centered care. The Senate Finance Committee is demonstrating important leadership by actively pursuing delivery and payment system reform as the foundation for broader reform efforts.

We believe that the policy options outlined in *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs* create a solid foundation for the upcoming discussions on health care reform. In particular, we appreciate the focus on primary care, chronic care, and care coordination; the array of payment strategies that promote value; and the infrastructure investments to assure we have the measures and processes in place to support delivery system reform. We support many of the options outlined and believe they lay a foundation to fundamentally change how care is provided in the United States. The attachment to this letter provides recommendations on some of the policy options described in your April 29th document. In addition we would also like to call your attention to five cross-cutting issues that we believe need to be explicitly included:

- Decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole. Whether within CMS or "above it," there needs to be transparent decision making processes that have – as integral elements – adequate representation of consumers and purchasers.

- Delivery system reform requires better engagement of consumers. Medicare should take the lead in assuring there is expanded public reporting of quality measurement data for all clinicians and all settings. In addition, Medicare should be directed to explore how vehicles such as shared decision-making and value-based benefit designs can become integral components to helping patients make the best decisions for themselves and to effectively partner with physicians and other clinicians who provide their care. The

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proposed Chronic Care Management Innovation Center (CMIC) should be given authority to test and broadly implement both provider payment innovations and innovations in consumer information and incentives.

- CMS should make Medicare data available to be merged with commercial data to support the development and dissemination of publicly reported provider performance information. Private-sector organizations should have access to Medicare data (maintaining patient privacy protections) to generate valid and reliable provider-specific performance reporting.

- The policy options include important recommendations on expanding the federal role in assuring that measures are developed to better meet patient needs and foster improvements in quality and affordability. Reform of payment and consumer information needs to explicitly reflect the use of these new, more impactful measures. As part of this migration, a greater focus needs to be placed on incorporating more consumer-relevant measures, such as outcomes, functional status, patient-centeredness, efficiency, and equity.

- Central to the health reform agenda is reining in rising health care costs. The policy options lay the foundation for reform that will reduce waste and promote higher value in health care. However, there need to be explicit mechanisms that will provide ongoing evaluation of the impact of payment and delivery system reforms on cost and quality. Just as is outlined in the recommendation for the Chronic Care Management Innovations Center, there should be an overall assessment and "learn as we go" process to assess and expand those models that employ effective cost control methods. There also needs to be a process for implementing payment changes and adjustments system-wide in order to reach the cost and quality goals of a reformed health care system.

Thank you for the opportunity to comment and work with you on this historic effort. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Peter V. Lee, Executive Direction of National Health Policy for the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,

Peter V. Lee
Co-Chair, Disclosure Project
Executive Director, National Health Policy
Pacific Business Group on Health

Debra L. Ness
Co-Chair, Disclosure Project
President
National Partnership for Women & Families

Attachment: Policy Options Detailed Comments

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Section I: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems

Linking Payment to Quality Outcomes

Establishment of a Hospital Value-Based Program

Moving from a pay-for-reporting to value-based purchasing (VBP) is critical, not only to increasing overall quality and improving health outcomes, but to achieving a system that rewards care coordination, reduces readmissions, improves outcomes, reduces costs, and addresses the significant disparities in health care being experienced due to race, gender, and ethnicity. We strongly support the proposed expansion of hospital VBP, and in particular we are pleased to see the inclusion of measures of patients' perspectives of care. HCAHPS has proven to be a strong and effective tool for measuring the extent to which a hospital's care delivery is patient centered.

We have the following suggestions for how to strengthen the overall hospital VBP concept:

- The measures on which hospital payments are made cannot be static. The Secretary should be given the authority and direction to incrementally move beyond existing RHQDAPU measures. Hospitals have already been reporting on these measures for five years and some measures have "topped out" in performance. Measures should address areas of poor performance and high variation among hospitals. Increasingly the hospital VBP program should include more consumer-centric measures such as outcomes, care coordination, efficiency, and disparities in care. The Secretary should engage in consultative processes, as described in the Stand for Quality recommendations, as new measures are considered for payment and public reporting (see www.standforquality.org).
- The transition from pay-for-reporting to value-based purchasing should be inaugurated sooner than 2013. Given that the first year would include only measures currently used in the RHQDAPU program, which have been in use for years, CMS should be directed to start implementing the process by having a mix of paying for reporting and performance in FY 2012.
- CMS should be directed to develop and use measures that can cut across settings, including those at the ambulatory surgical center and post-acute care levels. This will build a foundation that will facilitate measurement and payment for episodes of care, facilitate accountability across providers, and move the field away from measurement and payment silos.
- We fully support incrementally increasing hospital performance-based payments based on a 5 percent withhold. However, we urge you to determine payments based on a combination of improvement from the previous measurement period and performance relative to absolute standards. Based on our goal of implementing this component of hospital VBP in a budget neutral manner, we believe that the Committee should clarify that incentives should not be capped at the amount of the withhold if there are additional resources available.

Medicare Home Health Agency and Skilled Nursing Facility VBP Implementation Plans

We support the implementation of a value-based purchasing program for home health and skilled nursing facilities. This is a vital element of moving toward coordinated care and improved care transitions, and away from a system in which patients and providers exist in silos.

Physician Quality Reporting Initiative (PQRI) Improvements and Requirement

We support the proposed improvements to allow a physician's participation and completion of appropriate Maintenance of Certification (MOC) modules to satisfy PQRI requirements, where such provisions are at least equivalent to those otherwise required under PQRI. This will encourage alignment between quality improvement activities in public and private health programs.

While Congress awaits CMS' submission of their plan on value-based purchasing for physicians and professionals in 2010, we believe that there are elements where additional direction can and should be provided to CMS as it moves to value-based purchasing for physicians:

- Measures should increasingly migrate to those that assess variable levels of performance, rather than adherence to minimum standards of competence. To date the bulk of measures in PQRI are concentrated on discrete process measures, many of which are not directly linked to outcomes. There is an urgent need to migrate to measures of outcomes, functional status, patient-centeredness, and resource use, such as episode-based efficiency.
- Measurement of clinicians needs to expand beyond the current three self-selected measures. If providers can self-select measures, there should be criteria to guide that selection, such as requiring some measures for each specialty that address high impact areas of care, inclusion of patient-centeredness measures in all cases, or requiring selection of measures relevant to the majority of a particular clinician's Medicare patient pool.
- There should be a clear timeline to move expediently from a pay-for-reporting program to using payment to reward improvement or meeting absolute performance.
- The proportion of CMS payments to physicians that are directly linked to performance or improvement should increase as the program matures. The increase should ultimately be substantial and we support having at least 5% of payment tied to performance. We also support using incentives to achieve 85% participation in the program.
- There should be a timeline for publicly reporting all measures. Public reporting should always include "one-cycle" of reports only to practitioners, followed by subsequent cycles being made public.
- There need to be provisions to allow private-sector organizations to have access to Medicare data (maintaining patient privacy protections) to allow for the generation of all-payer data to facilitate the production of reports on physician performance. In allowing the use of Medicare data to produce physician-level reports, we would encourage consideration be given to require private entities using such data to comply with the Consumer-Purchaser Disclosure Project's "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs" (http://healthcaredisclosure.org/activities/charter/). The Patient Charter details strict terms

that sponsors of physician reporting programs must meet and is supported by a wide variety of stakeholders.

Primary Care

Primary Care and General Surgery Bonus

We view the proposal to provide a 5% Medicare bonus payment to providers of primary care services and general surgeons in rural areas as a step in the right direction, but it does not go far enough given the important value of primary care services and care coordination.

- We recommend an immediate bonus of 10%, which is consistent with the recommendation of the Medicare Payment Advisory Commission (MedPAC), but also think that additional cumulative increases of 5% should be added each of the next two years – for a total of 20%. These increases should be funded by reducing the physician-wide SGR update or from direct offsets from other areas.
- CMS should also be directed to develop and implement a process – to be completed in the next two years – that would establish appropriate valuation of specific services and of overall average compensation of primary care and other specialties, which would include restructuring of the RBRVS formula to consider not only cost inputs, but patient and societal value of services provided.

Payment for Transitional Care Activities

Hospital readmissions are a significant cost driver, as well as a major contributor to often avoidable pain and suffering for many patients. Patients routinely do not receive the information and support they need upon discharge from a hospital, resulting in one in ten Medicare beneficiaries being readmitted within 15 days and one in five back in the hospital within 30 days. There is obvious need for improvements in transitional care, but this will not be achieved without the development of a payment system that provides incentives and demands accountability for the kinds of care patients need in order to avoid readmissions. We need to eliminate the current financial silos that treat separately hospital, post-acute care facilities and out-patient care provided post-discharge. Regarding how to put payment for transitional care into practice, we recommend:

- Expanding the use of targeted intervention models – such as the Transitional Care Model – operating now in both the public and private sectors, which have been successful at improving the safety, effectiveness, and efficiency of transitions.
- As a condition of payment, requiring public reporting on key outcomes, including patients' experiences with transitional care.

Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration

Chronic Care Management

We strongly support the creation of a Chronic Care Management Innovation Center (CMIC) at CMS that has the authority to move quickly and expediently to test and then expand demonstration projects that evidence potential to improve patient outcomes and the affordability of care. This concept is a powerful one that should not be limited to only payment models related to beneficiaries with multiple chronic conditions, but should provide the Secretary with authority to test and expand – upon showing evidence from the Office of the Actuary – payment or consumer incentive models for a range of patients. In particular, the CMIC should:

- Have the authority to test and expand payment models that include strategies for addressing high cost/high burden conditions and procedures not only for populations with multiple chronic conditions, but other populations who are at the high risk for hospitalization or readmission, as well as sub-populations that experience disparities in care.
- Have authority and be directed to seek to align payments for Medicare, Medicaid, and Dual Eligibles to foster care higher value care, coordination and provider collaboration.
- The CMIC should have a multi-stakeholder advisory board to provide input and insight into the demonstration models, their testing methodologies, and the best strategies for implementation.
- Generally seek out opportunities to participate in, test and seek expansion of payment initiatives involving other public and private sector payers.

Hospital Readmissions and Bundling

Addressing the problem of preventable hospital readmissions is appropriately an area of focus for the Senate Finance Committee. We have the following comments regarding the options related to readmissions and bundling:

- Medicare should be required to adopt MedPAC's 2008 recommendation to publicly report hospitals' Medicare readmission rates as a condition of receiving any payment updates. Public reporting is a critical tool to lowering readmission rates, and will provide hospitals with significant incentives to focus on factors that lead to readmissions.
- The CMIC should be charged with developing and testing projects that encourage and implement public reporting of readmissions. This should include examination of the effects these efforts have on consumer and provider behavior.
- The CMIC should assess methodologies to bundle inpatient hospital payments with post-acute care services initiated within 30 days of discharge to provide hospitals and other post-acute care providers incentives for better care coordination and transition management services. In regard to these methodologies, we suggest:
    - CMS should be required to develop patient protection rules to ensure patients are able to access appropriate post-acute care, and that quality provisions in general are being met
    - Bundled payment methods should primarily focus on conditions (at least initially) where evidence has shown readmissions to be linked to factors that are hospital-based.

  - Bundled payments should be risk-adjusted based on the complexity of patients' conditions.
- Bundled payment policy should be aligned with other policies under the value-based purchasing and quality reporting options, so that a sufficient portion of hospitals' payment is contingent upon their performance on patient-centered measures of quality, including outcomes, functional status, use of shared-decision aids, and patient and family experience of care.

Moving from Fee-for-Service to Payment for Accountable Care

Sustainable Growth Rate

We believe that physician payment needs fundamental changes, including replacing the sustainable growth rate. The time during which the short-term fix is provided should be used to develop a better process that anchors the resource-based relative value scale in patient and societal values and provides triggers that will actually be acted upon to rein in costs when needed. One core element of this redesign should be the consideration of the SGR in concert with non-physician costs.

Extension and Expansion of the Medicare Health Care Quality Demonstration Program

We support expanding the Section 646 program to include multi-payer projects. We also suggest you require CMS participate in local and regional multi-payer projects through other demonstrations and pilots, to encourage alignment with private sector payers and improve the testing, evaluation and implementation of innovative payment models.

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform

Health IT

Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals

Many patients seeking care in underserved areas depend on the services of nurse practitioners and physician assistants for the majority of their health care needs. We support the expansion of Medicare incentive payments for the meaningful use of electronic health records (EHRs) to these professionals, as a step toward decreasing health disparities and making high quality, better coordinated care available to all. We also support having health information technology (HIT) incentives apply to health care providers who deliver post-acute services. Well-coordinated care requires that all who have a role in caring for a patient throughout his or her course of treatment have access to the information necessary for providing that care.

- As incentives are developed, we believe CMS should be directed to assure that HIT not solely focus on the important goal of supporting better point-of-care support for clinicians but also include patient-facing technologies, such as electronic access to individuals' personal health information and patient decision aids, to facilitate shared decision making.

Improving Quality Measurement

We applaud you for building on the good work that was begun in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the successful public-private partnership that has developed to advance the quality and safety of patient care.

We strongly support the Stand For Quality recommendations that are reflected in your proposal, but would underscore the need to:

- Provide federal support to develop measures to fill critical gaps;
- Require CMS to use newly developed and endorsed measures to foster improvement through their incorporation in public reporting and payment processes;
- Assure that the processes by which measures are selected for use in payment or public reporting are informed by consultative processes that engage the full range of stakeholders; and
- Support the implementation of an efficient national strategy for the collection of performance information.

Comparative Effectiveness Research

We applaud your leadership in promoting valid and actionable comparative effectiveness research. Without knowing what works best, it is impossible to get the information patients and their clinicians need to make evidence-based decisions about care. We need a robust federal commitment to comparative effectiveness research, and endorse your proposal to establish a long-term framework, financed with an all-payer trust fund. We also offer the following comments:

- We strongly support there being a transparent process that relies on all available evidence, considers the potential effects on subpopulations, and allows for public comment prior to any action that may use the results of comparative effectiveness research.
- We strongly believe it is essential to link the development of methods and standards for research with its intended use. Methods and standards cannot be viewed in a vacuum, and must reflect the needs of those who will be using the information to make practical, real-world decisions. Otherwise, these efforts will not lead to improved care.

Transparency

Nursing Home Transparency

Improving the quality and accountability of care for the most vulnerable older adults who reside in nursing homes is a critical aspect of a reformed health care system. We applaud your proposal to improve transparency of information about skilled nursing facilities and nursing homes. We fully support helping these patients, together with their family and caregivers, make decisions that lead to the most optimal care. We note the following:

- Transparency efforts should include a requirement that nursing homes adopt and be assessed on internal quality assurance and performance improvement standards to monitor and improve the quality of care provided to each nursing home resident.

- Public reporting is a critical aspect of improving care at the nursing home level. HHS should improve and expand the *Nursing Home Compare* website to reflect health and safety inspection reports so that patients and their families and caregivers have the information they need to make decisions about facilities.
- Efforts developed under policies related to nursing home and SNF transparency should be aligned with the SNF value-based purchasing policy described earlier in the report.

Workforce

There is significant need to address the critical shortage and lack of training pipeline for primary care and geriatric care providers. As the Medicare population grows, this need will further strain the health care delivery system, as the growing number of older patients who are living longer with multiple chronic conditions outpaces the number of health care providers with the knowledge and skills to provide the best possible care. We recommend the following:

- The range of alternative vehicles should be assessed and expanded to assure an adequate supply of needed physicians and other clinicians. Among the options that should be considered are linking educational loan repayment to working in primary care or in making a service commitment to the aging or other vulnerable populations; funding of graduate medical education positions; expansion of the National Health Service Corps or other options to attract more professionals to geriatric and primary care careers.

Section V: Public Program Integrity – Options to Combat Fraud, Waste, and Abuse

Efforts to improve integration and coordination often require a greater degree of clinical and financial integration among healthcare providers, and thus tend to implicate a broad array of laws and regulations governing competition, anti-kickback, self-referral, and other related issues. It is critical that regulatory standards support well-functioning markets and fosters competition. The Secretary of HHS should be called upon to review and recommend how policies and regulations would strike the appropriate balance between promoting coordination and not fostering anti-competitive practices.