

March 1, 2016

Mr. Andrew Slavitt, Acting Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: CMS Quality Measure Development Plan: Supporting the Transition to Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMS) (DRAFT)

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) draft Quality Measure Development Plan (MDP) posted on December 18, 2015 to comply with section 102 of the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA). We appreciate your staff's ongoing efforts to improve quality measurement systems for the complex Medicare program, particularly considering all of the competing demands on the agency.

Background

MACRA requires the Department of Health and Human Services (HHS) to create a draft plan for the development of quality measures for use in the new Medicare Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs). The final plan, taking into account public comments on the draft plan, is to be posted on the CMS website by May 1, 2016, followed by updates annually or as otherwise appropriate.

The MDP is designed to serve as a strategic framework for clinician quality measure development to support MIPS and APMs. Existing measures and policies from the Physician Quality Reporting System (PQRS), Value Modifier (VM), and the Electronic Health Record (EHR) Incentive Program will be the starting point for measures to be used in MIPS and APMs. Development of new measures funded under MACRA will begin to address gaps in the measure portfolio. According to the MDP, when considering measures, CMS will prioritize outcomes, person and caregiver experience, communication and care coordination, and appropriate use/resource use.

Comments

Focus on outcome measures in Medicare

Over the past few years, the Commission has become increasingly concerned that Medicare's current quality measurement programs are becoming "over-built," and relying on too many clinical process measures that are, at best, weakly correlated with health outcomes of importance to beneficiaries and the program. Relying on a large number of process measures reinforces payment incentives in Medicare fee-for-service (FFS) to overprovide and overuse measured services, as opposed to use the services appropriately. Process measures are also burdensome on providers to report, while yielding limited information to support clinical improvement.

CMS should move quickly to eliminate process measures that weakly correlate with health outcomes, measure basic standards of care, or reinforce the incentive to provide low-value care. CMS should also retire measures on which providers have achieved full performance (i.e., most providers report 100% or close to it).

Alternative approach to measuring Medicare quality

The Commission supports using more outcome quality measures in Medicare, but understands that measuring outcomes is challenging because of the need for adequate sample sizes, and the cost of collecting health outcomes data from patients. As detailed in the Commission's June 2014 and June 2015 reports to the Congress, an alternative approach to measuring Medicare FFS quality would use a small set of population-based outcome measures to evaluate quality at the population level in a local area. Possible measures include potentially avoidable hospital admissions, potentially avoidable emergency department visits, and potentially avoidable readmissions.

In our June 2014 report to the Congress, we acknowledged that while these population-based outcome measures would be a valid source of quality measurement, they would likely not be appropriate for adjusting FFS Medicare payments within a local area, because FFS providers have not explicitly agreed to be responsible for a population of beneficiaries. At least for the foreseeable future, FFS Medicare will need to continue to rely on some provider-based quality measures to make payment adjustments. However, CMS should use provider-based quality measures of health outcomes or intermediate outcomes where feasible, and eliminate the low-value process measures used in PQRS.

Core Quality Measures Collaborative

The MDP notes that CMS will continue to actively participate in the Core Quality Measures Collaborative to promote the development of core measure sets that support multi-payer alignment. Over the past 18 months, CMS worked with private sector payers and other stakeholders, to gain consensus around sets of physician quality measures. The seven core measure sets are intended to promote alignment of quality measures and reduce the burden and confusion physicians face as they track and report on a growing and diverse number of quality measures across payers. CMS is already using measures from each of the core sets in PQRS, VM, EHR Incentive Program, and the Medicare Shared Savings Program.

The Commission applauds CMS's commitment and the efforts of the Collaborative to align and harmonize measures used by public and private payers. However, the first core sets of the

Collaborative continue the trend of focusing on process, rather than outcome measures. For example, only about a quarter of the measures in the “Accountable Care Organizations, Patient Centered Medical Homes, and Primary Care Core Set” are outcome or intermediate outcome measures. The core sets are thus inconsistent with the vision of MDP to include measures that “emphasize outcomes, including global outcome measure and population-based measures, balanced with the process measures that are proximal to outcomes.” The Commission supports the MDP’s emphasis on outcome measures, in particular population-based outcome measures, and CMS should maintain that focus in its work with the Collaborative.

Conclusion

The Commission appreciates the opportunity to comment on the draft MDP. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of these comments, please feel free to contact Mark Miller, MedPAC’s Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive style.

Francis J. Crosson, M.D.
Chairman