MEDPAC Medicare Payment Advisory Commission

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January 5, 2015

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS List of Measures under Consideration for December 1, 2014

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) "List of Measures under Consideration for December 1, 2014," issued by the agency to comply with section 1890A(a)(2) of the Social Security Act, which requires the Department of Health and Human Services (HHS) to make publicly available, no later than December 1 of each year, a list of certain categories of quality and efficiency measures that it is considering for adoption through rulemaking for the Medicare program. We appreciate your staff's ongoing efforts to administer and improve quality and resource use measurement systems for the complex Medicare program, particularly considering all of the competing demands on the agency.

Background

This year's "list of measures under consideration" is a 329-page document listing hundreds of quality and resource use measures. Under the statute, CMS may consider including any of these measures during upcoming rule-making for over 20 Medicare quality reporting and value-based purchasing (VBP) programs. The list does not include the dozens of measures already adopted for Medicare's quality programs, only potential new measures (during the rule-making process, CMS may delete as well as add measures to each program). Table 1 summarizes the number of measures under consideration for each of these programs.

Table 1. Count of measures under consideration by program, December 2014

CMS program[1]	Number of measures under consideration
Medicare Shared Savings (ACOs)	116
Physician Feedback/Quality and Resource Utilization Reports	102
Physician Value-Based Payment Modifier	102
Medicare Physician Quality Reporting System	96
Physician Compare	96
Medicare/Medicaid EHR Incentive Programs for Eligible Professionals	31
Hospital Inpatient Quality Reporting	29
Hospital Outpatient Quality Reporting	16
Hospital Value-Based Purchasing	12
Ambulatory Surgical Center Quality Reporting	9
PPS-Exempt Cancer Hospital Quality Reporting	9
End-Stage Renal Disease Quality Incentive Program	7
Inpatient Rehabilitation Facility Quality Reporting	6
Inpatient Psychiatric Facility Quality Reporting	4
Long-Term Care Hospital Quality Reporting	4
Medicare/Medicaid EHR Incentive Programs for Eligible Hospitals/CAHs	4
Hospital-Acquired Condition Reduction Program	2
Home Health Quality Reporting	1
Hospital Readmission Reduction Program	1
Skilled Nursing Facility Value-Based Purchasing Program	1
Hospice Quality Reporting	0

[1]A single measure may be under consideration for more than one program.
Notes: ACOs (accountable care organizations); PPS (prospective payment system); CAHs (critical access hospitals).

A significant constraint on CMS's discretion concerning this list of measures should be acknowledged. We understand that the published list contains more measures than will ultimately be adopted by CMS for Medicare's quality reporting and VBP programs. CMS is required by law to publish this list by December 1 each year in order to give stakeholders an initial opportunity to view and comment on possible measures before some of them are formally proposed for program adoption in future rule-making. Therefore from CMS's perspective, it makes sense to include as many measures as possible on each year's list, so that the Measure Applications Partnership (MAP), the multi-stakeholder groups convened by the National Quality Forum (NQF) under contract with HHS, can provide their input on all potential measures.

Comments

Rather than focusing on the technical details of particular measures, or discussing whether certain measures should or should not be included in a given provider-level quality measurement program, our comments address broader concerns with Medicare's current approach to quality measurement. This year's 329-page list of measures under consideration is a telling symptom of the larger problem. Over the past few years the Commission has become increasingly concerned that Medicare's current quality measurement approach is becoming "over-built," and is relying on too many clinical process measures that are, at best, weakly correlated with health outcomes. Depending on a large number of process measures reinforces undesirable payment incentives in FFS Medicare to increase the volume of services and is overly burdensome on providers to report, while yielding limited information to support clinical improvement or beneficiary choice. Instead the Commission has urged more focused attention on a small number of population-level outcome measures, such as potentially avoidable hospital admissions, emergency department visits, and readmissions.

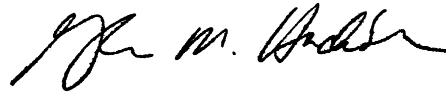
In our June 2014 report to the Congress, we acknowledged that these population-based outcome measures would not be appropriate for adjusting FFS Medicare payments within a local area, because FFS providers have not explicitly agreed to be responsible for a population of beneficiaries. Therefore, at least for the foreseeable future, FFS Medicare will need to continue to rely on some provider-based quality measures to make payment adjustments. However, the sheer size of the December 2014 list of measures under consideration reinforces our concerns that Medicare's provider-level measurement activities are accelerating without regard to the costs or benefits of an ever-increasing number of measures. We urge CMS to keep this broader perspective in mind as it moves into the proposed rule process for each Medicare program, and carefully consider whether each additional measure would simply reinforce or exacerbate the current system's problems.

Conclusion

The Commission appreciates the opportunity to comment on the December 2014 list of measures under consideration. 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 our comments, please feel free to contact Mark E. Miller, the Commission's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH, JR, WC