MEDPAC Medicare Payment Advisory Commission

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June 2, 2006

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: file Codes CMS-1488-P IV.
Sections A. and B.

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the two quality-related sections in CMS's proposed rule entitled *Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates*, Federal Register Vol. 71, No. 79, pages 23996-24472 (April 25, 2006). In this letter our comments are on the hospital quality data and value-based purchasing provisions of the proposed rule. Our comments on the rest of the proposed rule are forthcoming.

We applaud your ongoing efforts to improve the quality of care for Medicare beneficiaries by developing measures and collecting information on hospital quality, particularly given CMS's many competing priorities.

Specifically, we support your efforts to develop a plan to move forward on hospital pay for performance. Currently Medicare pays high- and low-quality providers the same. Medicare needs to change the incentives of the system and base a portion of provider payment on performance. We believe a sufficient number of accepted quality indicators are available to move ahead quickly on hospital pay for performance. We elaborate on these and other potential measures as well as other design issues in our comments on value based purchasing.

Hospital quality data
We support the expansion of measures outlined in this proposed rule. In addition we offer suggestions to improve the existing set.

CMS should set a date certain for including HCAHPS as a part of the required data set. We agree that HCAHPS will add an important dimension to the measure set. To help hospitals prepare, the final rule should establish a firm date upon which CMS will require

HCAHPS data in the set of measures that must be reported to CMS as a condition of receiving the full annual update. We suggest that CMS state that it intends to use information from fiscal year 2008 as a condition for receiving the full update in 2009. This will encourage hospitals to begin to collect the information beginning fiscal year 2007 and provide hospitals and CMS time to become familiar with collecting, reporting, and analyzing the information before it is linked with the annual update and value-based purchasing program.

Delete oxygenation assessment from the measure set. The Deficit Reduction Act (DRA) states that CMS has the ability to replace measures "where all hospitals are effectively in compliance." The scores on the oxygenation assessment measure for patients with pneumonia have reached such high levels that they no longer provide meaningful information upon which to distinguish hospitals. The average performance on this measure is 99 percent, thus virtually all hospitals are in compliance. Retiring this measure, while a modest step, would provide an important signal to hospitals that CMS is willing to reduce the burden of data collection as the set evolves.

To ensure data completeness, CMS should, in addition to attestation, audit data from a randomly chosen, small number of hospitals. The provisions in the proposed rule require hospitals to sign an attestation that the sample of claims submitted to qualify for the Reporting Hospital Quality Data for Annual Payment Update is a fair sample of all patients discharged from their facility. The Commission supports this requirement. CMS may also want to consider strategies to audit data.

Value-based purchasing

It is essential for the Medicare program to become a value-based purchaser. This section of the proposed rule identifies a number of important issues for creating such a program. As you know, the DRA asked the Commission to address many of the same design issues for home health agencies, and we hope to coordinate closely with you and your staff as we develop our report. Further, the Commission is working on strategies to measure physician and inpatient resource use and will continue to coordinate with your staff on those issues.

General design issues. The Commission strongly supports differentiating provider payment on the basis of quality. In March 2004 we recommended that Medicare do so for Medicare Advantage plans and for settings of care and physicians that treat beneficiaries with end stage renal disease. In March 2005 we recommended differentiating payment on the basis of quality performance for physicians, hospitals, and home health agencies. The Commission also developed criteria for determining which measures to use and design principles, and assessed a wide variety of measure sets. Our comments on this section are based on those discussions.

The goal of pay for performance should be to improve care for as many beneficiaries as possible by as much as possible. This has implications for a variety of design issues in a value-based purchasing program. It is one reason that the Commission recommended

that Medicare reward both improvement *and* attainment. Rewarding both will provide incentives for all providers to respond. By providing an incentive for providers in regions with low scores, it may also address some of the regional variation in quality performance.

To minimize major disruptions, the program should be funded initially by setting aside a small portion of base payments—1 percent or 2 percent. The Commission intends the program to be budget neutral, but the amount channeled into pay for performance should grow over time. It should be an expectation of the Medicare program that a portion of provider (in this case hospital) payment be based on the provider's performance on quality.

The measures. As the proposed rule notes, it is important to capture a broad set of services and thus a complete picture of the quality of care. The two sets contemplated by this proposed rule—the 10 current and 11 additional process measures in the Hospital Quality Alliance set and HCAHPS—are a good start. Together they provide information on patient perception of care and clinical effectiveness, two of the Institute of Medicine (IOM) goals for a quality health system. However, the program also needs information on safety, one of the other IOM goals. Improving patient safety can be encouraged by measuring the adverse outcomes of poor safety.

Linking the information mandated by the DRA on secondary diagnoses present on admission with safety indicators from administrative data could enhance CMS's ability to assess patient safety. To make measures of patient safety more useful, MedPAC recommended in March 2005 that CMS require hospitals to report this information on all admissions. This information could be used to help identify which conditions patients had when they entered the hospital and which ones may have been the result of unsafe care. One set of indicators to which this information could be linked is the Agency for Healthcare Research and Quality's patient safety indicators.

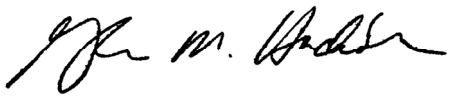
While reporting secondary diagnoses present on admission is a new responsibility for hospitals, it is information that could be used for many important purposes. This information could be helpful in adjusting for patient risk for quality outcome measures, and also in determining patient complexity for payment purposes. Further, many hospitals already collect the information because two large states—California and New York—require its collection. The National Uniform Billing Committee has included a field on the UB04 to accommodate this information.

From the proposed rule, it is unclear to us whether the agency intends to collect the information on all secondary diagnoses for all admissions. We believe this issue needs to be clarified in the final rule. As noted, the Commission believes this information is useful for a wide variety of functions and thus, CMS should collect all secondary diagnoses for all admissions.

Include measures of functions supported by the use of information technology in the value-based purchasing program. The Commission made this recommendation in March 2005. Adoption of clinical IT by providers has the potential to improve the quality, safety, and efficiency of health care. Because the benefits of IT result from its use for specific quality-enhancing functions, Medicare should incorporate measures of quality-enhancing functions supported by the use of information technology in any initiative to financially reward providers on the basis of quality. CMS should work with researchers, quality experts and hospitals to identify functions, such as medication reconciliation, that information technology supports and develop measures of their use.

Again, we look forward to continuing to work together to improve the Medicare program's ability to measure and reward quality and efficiency. If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman