MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Jack C. Ebeler, M.P.A., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

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Thomas Valuck, MD, JD
Center for Medicare Management
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C5-15-02
Baltimore, MD 21244-1850

Attn: Physician VBP Program Issues Paper Comments

Dear Dr. Valuck:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the *Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services: Issues Paper* released by the Centers for Medicare and Medicaid Services (CMS) on November 26, 2008.

MedPAC recommended in its March 2005 report to Congress that Congress should establish a quality incentive payment policy for physicians in Medicare, and we recommended in our March 2005 and 2008 reports that CMS measure physicians' resource use and share the results with physicians. MedPAC continues to strongly support CMS's efforts to move Medicare toward value-based purchasing (VBP) for physician services.

This letter provides MedPAC's comments on several of the policy and program design questions raised in the Physician VBP Program Issues Paper. These comments are intended to assist CMS as the agency continues its development of a report to Congress with recommendations for legislative and administrative actions to implement a physician VBP program for Medicare. The letter is organized according to the structure of the questions in the Issues Paper.

While the implementation of a physician VBP program will be an important step forward, both the Commission and CMS should be and are focused on crafting more fundamental payment policy changes that are necessary to maximize the benefits of value-based purchasing for Medicare. As long as Medicare's payment systems continue to perpetuate the existing "silos" in the patient care delivery system—physicians paid separately from hospitals, both paid separately from post-acute

care providers, and so on—there is only so much value improvement that Medicare can ever realize. Medicare can achieve more value-based purchasing power in the fee-for-service program by implementing new payment policies that cut across provider silos, for example by using bundled payments to align financial incentives and quality measures between hospitals and physicians.

Overarching Questions

In general, the Commission supports all of the stated objectives, assumptions, and design principles outlined in the Physician VBP Program Issues Paper. We offer specific comments in response to questions in the Issues Paper, but emphasize the following overarching points:

- The physician VBP program should include performance measures that are strategically selected to address significant gaps in quality and high-cost or high-volume services that may deliver little or no value to Medicare patients. The measures used in the program should evolve as we develop a better clinical evidence base and greater understanding of the benefit-cost trade-offs of particular services and treatments. Ideally, the program should only use measures where, on the basis of clinical evidence, the benefit of the service measured exceeds its cost. All of the measures used in the program should be endorsed by the consensus-based performance measure evaluation entity, such as the National Quality Forum, with which the Secretary will contract as directed under section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

- The physician VBP program should be designed to promote providers' clinical and financial accountability across care settings by aligning measures and incentives across providers and settings, such as through the application of care coordination measures and the use of patient-centered episodes of care for measurement of quality and resource use. The measure set should encourage effective management of beneficiaries with chronic conditions by focusing on evidence-based measures of quality that include ambulatory care-sensitive and preventable hospital admissions and readmissions.

- The measures used should not allow physicians to receive rewards for providing marginally effective care or care that is already routinely furnished. Measures based on this type of care could work at cross-purposes to the program's goal of increasing the efficiency, as well as the quality, of physician services delivered to beneficiaries.

- The physician VBP program should accelerate the adoption of health information technology (HIT) that can effectively support the data needs of the program, for example by focusing rewards on the use of HIT systems that report the quality measurement and resource use data in formats specified by CMS for use in the program.

Accommodating different practice arrangements, such as multi-specialty groups, single-specialty groups, small practices, and institution-based practices, will inherently increase the complexity and costs of the physician VBP program for CMS. Nonetheless, we agree that the program, at least at the outset, will need to accommodate as many types of practices as possible to increase provider interest and participation. Over time, however, we suggest that the program's incentives be weighted to encourage development of more integrated delivery system models wherever feasible.

The Commission agrees that it is vital to design the physician VBP program so that it reduces or at least does not worsen existing disparities in access to health care services. One approach is to apply risk-adjustment to outcome measures where appropriate to reflect population-level health differences that have been shown to be correlated with health care disparities. Another approach is to base rewards on providers' improvement over their previous performance, as well as rewarding attainment for regional or national benchmark levels of performance. Rewarding improvement and attainment will provide an incentive for all providers, including those serving disadvantaged populations, to participate in the physician VBP program.

Measures

Which quality measures should be used?

The Commission has outlined the following criteria for any performance measures that would be used in a Medicare VBP program:

- Measures should be well-accepted and evidence-based, and should be familiar to providers.
- Collecting and analyzing measurement data should not be unduly burdensome for either the provider or the Medicare program.
- Measures should not discourage providers from taking riskier or more complex patients. Process, structure, and patient experience measures are—in general—not affected by patient complexity. Risk adjustment is critical for outcomes measures.
- Most providers should be able to improve on the available measures. Aspects of care being measured should be within the control of the provider, there should be room for improvement in the quality of care being measured, and the measure set should include those that apply to all patients, such as safe practices and patient perceptions of care.

Quality measures are available for many types of physician specialties, and the number of measures available has increased significantly over the past few years. However, measuring physician quality remains more complex than measuring quality in other care settings because of the lack of readily accessible clinical data, the wide variety of specialized services, and the sheer number of providers of physician services. These complexities led the Commission to recommend a two-step implementation strategy for VBP for physicians.

The first step would have physicians report on whether they have certain HIT functionality, that is how their information systems track and follow-up with their patients. Examples of these types of measures include: whether physicians had patient registries to identify and track patients with coronary artery disease, or whether physicians treating patients in hospitals took responsibility for ensuring that patients received their recommended follow-up. These measures would apply across all types of physicians. The measures may best be achieved through using advanced clinical information technology, so they would also encourage providers to adopt HIT. Doing so would also help move to the second step by building the infrastructure necessary to measure and improve processes of care.

The second step, two to three years later, would move to measuring physicians' clinical processes of care for different health conditions. While many of these measures are available and are already being used in private purchasers' pay-for-performance programs, they are not yet available for every type of patient or physician. To encourage specialty societies and other measure developers to speed development of these types of measures, Medicare should establish a date certain when all physicians will be measured on their performance on processes of care relevant to their patients.

The Commission has emphasized the importance of using measures that are vetted and periodically re-evaluated by a credible, independent entity. This entity would examine measures for statistical validity and reliability, and evaluate each measure's relative usefulness in improving the outcomes of care for beneficiaries, such as the potential impact of the care process or structural component being measured on improving health outcomes for beneficiaries care. In MIPPA, Congress directed the Secretary to contract with a consensus-based performance measure evaluation entity, such as the National Quality Forum, which will be charged with evaluating and maintaining valid, reliable, evidence-based performance measures that are consistent across provider types and settings. All of the measures used in the physician VBP program should be endorsed by this entity. Medicare should lead the way in harmonizing measure specifications within and across provider types, which will decrease providers' costs for reporting measurement data, and increase providers' and consumers' confidence in the validity and usefulness of the measures.

The Commission also recognizes that certain types of physicians, including those in small practices, located in rural areas, and/or focused on specialized services with small numbers of patients, will report small numbers of cases for the calculation of some of the proposed performance measures. Performance scores for these physicians could vary substantially from measurement period to measurement period solely based on random statistical variation, which in turn could reward or punish these providers for using reasons unrelated to their actual quality or efficiency. In these cases, the Commission has suggested using composite measures or performance data from multiple years when determining performance scores for providers in these situations.

Which resource use measures should be used?

The physician VBP program should use individual physicians as the basic building block of resource use measurement, but be capable of aggregating these measures in multiple ways, such as by physician group practice and by accountable care entities. This capacity will allow the program maximum flexibility in applying the measurement results in multiple ways for any eventual confidential or public reporting, payment incentives, or other policy goals. It also will allow the program to measure the 40 percent of physicians who continue to practice as solo practitioners and will help to avoid problems in markets where group practices are so large and command so much market share that there are too few peers for comparison.

The physician VBP program should have the flexibility to measure physician resource use on a per episode and per capita basis. Together these measures more fully capture the relevant characteristics of physicians' practice patterns, by revealing physicians' resources used in an episode and the number of episodes per patient. Relying on either measure alone could mask differences between physicians and even allow gaming. Additional measures, such as rate of generic drug prescribing, should also be included when warranted to produce a more complete picture of resource use. However, the program should not be delayed until all of these measures

are ready. Instead, the program should begin with as many appropriate measures as it reasonably can and transition to implementation of the full measurement set. It should be flexible enough to weight or even exclude any of these measures where appropriate.

The program's measurement methodology and a description of the data used should be made publicly available. Currently, CMS's Resource Use Report pilot relies upon commercially available episode grouper software packages. This allows Medicare to evaluate *features* of the software packages that can be included in a Medicare-specific software package. MedPAC has never expected Medicare to purchase off-the-shelf software; Medicare regularly contracts with vendors to develop tailored programs, such as DRGs. The final program used for physician resource use measurement should also use a Medicare-specific, transparent method. The program should be designed to measure physician resource use so that it can provide physicians with both summarized data and more detailed information, such as break-outs by type of service. It must adjust data for beneficiaries' health status and other characteristics to measure resource use as appropriately as possible.

Ideally, changes in physicians' year-to-year resource use measurement results should be due to changes in their practice patterns alone rather than changes in measurement methods. However, this program will be an entirely new endeavor for Medicare. It is unrealistic to expect that the measurement methodology that they use in the first year will remain unchanged in the future. One way to help deal with this would be to pilot test any future refinement by including new measures, highlighted as such, in detailed feedback for a year or two before including them in overall scores.

How should measures be combined?

The Commission defines efficiency using both cost and quality. True efficiency cannot exist in the absence of either. While we understand the need to begin the physician VBP by dealing with these aspects separately, we urge CMS to move quickly to measuring, reporting, and rewarding efficiency as a whole.

Incentive Structure

The physician VBP program should reward physicians based on both improving care and attaining or exceeding specified benchmarks. The goal of pay-for-performance is to improve care for as many beneficiaries as possible. Thus, it is important both to reward physicians who attain certain thresholds of quality, while all also ensuring that all physicians are encouraged to improve care and have an opportunity for rewards under the program. It is reasonable to expect that, over time, physicians' performance will converge as more physicians raise their performance to the attainment benchmark.

The program should be funded by setting aside, initially, a small proportion of payments. To ensure minimal disruption for beneficiaries and physicians, the Commission recommends that, at least initially, the percentage of dollars should be small (perhaps 1 percent to 2 percent of payments). As our ability to measure performance improves, this amount should increase significantly.

Data Strategy and Infrastructure

The Commission suggests that, at least initially, claims data should be the source of data for the process measures used in the physician VBP program, as these data are the least burdensome to physicians and CMS. While claims-based process measures are not available for every type of condition or specialty, they are increasingly available for many conditions of importance to Medicare beneficiaries and physicians. Claims data would be an even better source for quality measures if they were linked to prescription (from the Part D program when available) and laboratory value data (obtained through laboratories). The Commission has recommended that these data be collected and linked with physician claims to improve quality measurement. Additional process of care measures can be derived from medical record abstraction, patient registries, flow sheets, or electronic health records as these become more widely implemented.

Much of the data collection and validation infrastructure and processes for the physician VBP program will build on investments made by CMS over the past few years in implementing Medicare's current physician quality data reporting initiative. However, CMS will need to increase the amount of resources it devotes to implementation and oversight of the physician VBP program in order to ensure the accuracy and reliability of the performance data submitted by the hundreds of thousands of physicians and other professionals who will participate in the program. The Commission has urged the Congress to give full consideration to funding requests from the Secretary related to implementation of the physician VBP program.

Public Reporting

Public reporting of Medicare physicians' performance would be a transformative step toward Medicare becoming a value-based purchaser. Medicare has truly led efforts in measuring and reporting the quality of hospitals, Medicare Advantage plans, skilled nursing facilities, and other types of providers. This depth of experience could soon be applied to physicians. Public reporting would allow physicians to know how their practice patterns compare with those of their peers and would allow beneficiaries and other providers to use this information when they make health care and referral decisions.

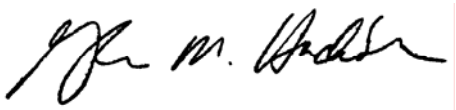
However, the Commission is concerned that moving too rapidly towards public reporting could lead to a flawed physician VBP program and that even the appearance of moving too rapidly could undermine physician and beneficiary confidence in public reporting. The physician VBP program will need to balance these concerns with the potential benefits of public reporting. The Commission has recommended that Medicare design physician measurement so as to be prepared for any eventual public reporting and payment adjustments. The Commission is eager to learn about Medicare's and physicians' experience with the new confidential feedback program and this experience should inform decisions about the future direction for the physician VBP program.

If any public reporting of physician performance, either quality, resource use, or both, is implemented in the future, the Commission encourages Medicare to incorporate what the agency and others have learned about how consumers process information into designing the public reporting mechanism. It should be flexible enough so that most beneficiaries can use it to glean high-level, general information and that savvy, motivated beneficiaries can use it to gather more detailed information. It should also have the capacity serve as a resource for professional or other informed beneficiary advisers.

The physician VBP program should strive to publicly report at the level that beneficiaries select their physicians and offer flexibility for tailored use. For example, a beneficiary who receives his primary care at a small family medicine practice where his appointments might be with any of the physicians in the practice would most likely want to consider the performance of the group as a whole. On the other hand, the same beneficiary could seek cardiology care at a large multispecialty group practice with numerous satellite offices. If the beneficiary planned to visit only one of those offices and use only cardiology care, more aggregated performance measures would not be as helpful for him.

We thank you for considering these suggestions and look forward to continuing to work with you as the physician VBP program evolves.

Sincerely,



Glenn Hackbarth, J.D.
Chairman