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
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

April 1, 2008

The Honorable Max Baucus
Chairman, Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles E. Grassley
Ranking Member, Committee on Finance
U.S. Senate
135 Hart Senate Office Building
Washington, DC 20510

The Honorable Charles B. Rangel
Chairman, Committee on Ways and Means
U.S. House of Representatives
2354 Rayburn House Office Building
Washington, DC 20515

The Honorable Jim McCrery
Ranking Member, Committee on Ways and Means
U.S. House of Representatives
242 Cannon House Office Building
Washington, DC 20515

Re: Department of Health and Human Services *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program* (November 21, 2007)

In accordance with Section 5001 of the Deficit Reduction Act of 2005 (Public Law 109-171), the Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the Department of Health and Human Services *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program* (November 21, 2007). MedPAC strongly supports using Medicare payment policy to reward improvements in quality.

MedPAC first recommended the adoption of a pay-for-performance program for Medicare inpatient hospital services in our June 2005 Report to the Congress. Our March 2008 Report to the Congress recommends the implementation of a quality payment incentive program concurrent with the annual update to the inpatient hospital prospective payment system (PPS) in fiscal year (FY) 2009. MedPAC strongly supports the Secretary's effort to move Medicare toward value-based purchasing. To assist the Congress as it considers legislation to authorize the Secretary to implement a Medicare hospital VBP program in 2009, this letter provides our comments on specific policy and program design issues raised in the report.

Comparing the Secretary's proposed hospital VBP plan with MedPAC's Medicare pay-for-performance (P4P) criteria

In our March 2005 and June 2007 Reports to the Congress, MedPAC laid out several design criteria for Medicare VBP programs (which we refer to as pay-for-performance, or P4P, programs), including specific comments about the design of a hospital P4P program. The

following section of this letter compares the relevant elements of the Secretary's hospital VBP report to MedPAC's criteria.

Reward providers based on both improving care and exceeding certain benchmarks. The goal of pay-for-performance is to improve care for as many beneficiaries as possible. Thus, it is important both to reward providers who attain certain thresholds of quality, and to ensure that all are encouraged to improve care and have an opportunity for rewards.

> **Summary of proposal:** The Secretary proposes to score each participating hospital's performance on each measure by using either an "attainment score" (performance relative to the national average for all hospitals) or "improvement score" (performance relative to the hospital's prior year performance), whichever is higher.
>
> **Comment:** The Secretary's proposal is consistent with MedPAC's criterion. Providers should be rewarded for attaining high thresholds of quality performance or for making significant improvements over their own prior-year performance. It is reasonable to expect that, over time, these thresholds will converge as more hospitals raise their performance to the national attainment benchmark.

Fund the P4P pool by setting aside, initially, a small proportion of payments. To ensure minimal disruption for beneficiaries and providers, MedPAC 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 quality improves, this amount should increase significantly.

> **Summary of proposal:** The Secretary proposes to set aside 2 to 5 percent of all base operating DRG payments to create the pool of incentive payment funds. Payments to hospitals for capital costs, IME, and DSH would not be part of the basis of the incentive payment.
>
> **Comment:** The Secretary's proposal is consistent with MedPAC's criterion. In general, MedPAC believes that incentives for Medicare P4P programs should be applied to a small percentage of all base provider payments, in order to create a strong yet reasonable incentive for quality improvement. It may be desirable to start with the lower end of the proposed percentage range (i.e. 2 percent) and then gradually increase it over the first few years of the program as Medicare and providers gain implementation experience.

Distribute all payments that are set aside to providers achieving the quality criteria. Although savings could accrue from improved quality, the goal of our recommendations is improved quality, not saving dollars. Therefore, MedPAC intends for all of the withheld dollars to be distributed.

Summary of proposal: Under the Secretary's proposed incentive payment distribution system, it is likely that some individual hospitals would not earn all of their potential incentive payment, thereby resulting in a pool of temporarily unallocated funds. The report considers that some or all of these funds could be re-distributed to high-performing hospitals as additional quality incentive payments, for example on a *pro rata* basis to all hospitals that earned an incentive payment. The report also considers that some or all of the undistributed quality incentive funds could be retained as program savings.

Comment: MedPAC has suggested that Medicare P4P programs should be budget neutral. Thus, in this case we suggest that any undistributed quality incentive funds should be redistributed, for example to high-performing hospitals as additional incentive payments, and not retained for program savings.

Use performance measures that meet certain criteria. MedPAC has outlined the following criteria for the performance measures that would be used in a Medicare P4P 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.
- Incentives 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.

Summary of proposal: The Secretary's proposed starter measure set includes 17 clinical process measures, 2 clinical outcomes measures, and 8 measures of patient experience collected with the Hospital-CAHPS survey.

Comments: The proposed list is substantially consistent with MedPAC's suggested list of measures presented in our March 2005 Report to the Congress. As noted in our March 2005 Report, we suggest that the Secretary consider adding the following 3 structural measures from

the National Quality Forum/Leapfrog Group "Safe Practices" measure set, as recommended by the Institute of Medicine (IOM)[a]: Computerized Physician Order Entry, ICU Physician Staffing, and Evidence-Based Hospital Referrals.

We also encourage CMS to expand the number of patient safety measures included beyond the two surgical care infection prevention measures in the starter set. The report states that the hospital VBP program will add additional patient safety measures after the first year of implementation if they are available. Possible additional areas to include are measures of post-operative infections, central line infections, and ventilator associated pneumonia.

Evolution of hospital VBP measure set: As the hospital VBP program evolves, MedPAC believes that additional measure selection should be strategic, i.e. focused on areas of provider performance where there are significant opportunities for quality and efficiency improvements, both within and across provider types. Measures should be designed to send consistent signals about Medicare's expectations for quality and efficiency improvement to hospitals, physicians, and other providers who treat beneficiaries. To that end, MedPAC strongly supports the Secretary's comment in the report that the agency is developing new measures that will promote coordination of care across settings, patient centeredness, longitudinal assessment, and shared provider accountability, in addition to clinical quality.

Inclusion of efficiency measures: Efficiency measures are not included in the list of potential measures for the start of the VBP program, but the report indicates the Secretary intends to include them as soon as FY 2010 or 2011. MedPAC believes efficiency measures should be included in the hospital VBP program as soon as possible. The report also indicates that the Secretary wants to be able to link resource use to quality, starting at a minimum with the 2 proposed 30-day mortality measures. Another option is to include an efficiency measure based on reducing hospital-specific per-beneficiary spending and/or readmission rates. There are issues that would need to be worked out in using such measures, such as hospital-specific risk adjustment and appropriately assigning accountability for readmissions to the hospital, to the patient's physician or post-acute care provider, etc., but these issues should not unduly delay the introduction of efficiency measures into the program. The Commission believes that a P4P program will be incomplete until it includes measures of both quality and provider resource use.

Process for development of performance measures: We support the Secretary's comments in the report acknowledging the need for measurement to evolve rapidly beyond the proposed starter measure set, particularly outcome measures and measures of patient safety. MedPAC stated that measure development, validation, and evolution should take place in an open, formal, routine process that is managed by a public/private body including representatives of the major

[a]Institute of Medicine. 2007. *Rewarding provider performance: Aligning incentives in Medicare.* Washington, DC: IOM.

stakeholders and armed with the requisite clinical and analytical expertise. The Institute of Medicine (IOM) has recommended the creation of an independent entity that would coordinate the development of performance measures using a process designed to synchronize provider performance measures used by Medicare and private payers[b].

Small numbers for individual performance measures and rural hospitals: MedPAC has recognized that certain types of hospitals—including hospitals that are small, located in rural areas, and/or primarily focused on stabilizing patients and then transferring them to larger hospitals—will report small numbers of cases for the calculation of some of the proposed performance measures. The Secretary's report observes that the resulting performance scores reported for these hospitals could vary substantially from period to period solely based on random statistical variation, which could reward or punish these hospitals for changes in their performance scores that are possibly unrelated to the hospital's actual behavior. In these cases, MedPAC has suggested the consideration of additional measures, or using alternative ways of calculating scores on the measures used for all hospitals, such as using performance data from multiple years.

Comment on HHS resources for implementation: Much of the data collection and validation infrastructure and processes for the hospital VBP program will build on investments made by the Secretary over the past few years in implementing Medicare's current hospital quality data reporting initiative. However, as noted in the Secretary's report and in recent testimony from the Government Accountability Office[c], HHS will need to increase the amount of resources it devotes to oversight of the hospital VBP program in order to ensure the accuracy and reliability of the performance data submitted by hospitals participating in the VBP program. MedPAC urges the Congress to give full consideration to funding requests from the Secretary related to implementation of the hospital VBP program.

While this report is an important step forward, both MedPAC 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—hospitals, separate from physicians, separate 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

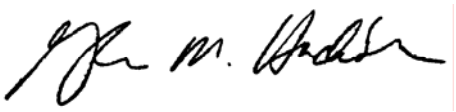
[b] Institute of Medicine. 2006. *Performance measurement: Accelerating improvement.* Washington, DC: IOM.

[c] Government Accountability Office. 2008. *Hospital quality data: Issues and challenges related to how hospitals submit data and how CMS ensures data reliability.* March 6. Washington, DC: GAO.

measures between hospitals and physicians. Building on its past work in this area, MedPAC looks forward to making recommendations to the Congress about these more fundamental reforms in our June 2008 Report to the Congress and beyond.

MedPAC appreciates this opportunity to comment on this important report to Congress from the Secretary. 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

GMH/jr/w