

Consumer-Purchaser

DISCLOSURE

PROJECT

Improving Health Care Quality through Public Reporting of Performance

June 22, 2006

Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Endorsement of Need to Expand Measurement, Public Reporting and Value Payment Support for Disclosure Project's June 12, 2006 Comments on Hospital Quality Reporting and Value-based Purchasing and Health Care Information Transparency Initiative (CMS-1488-P: Changes to the Hospital Inpatient Prospective Payment System)

Dear Secretary Leavitt and Dr. McClellan:

The undersigned organizations sincerely welcome and thank you for the significant strides that you have made to provide consumers with comparative quality and cost information. In particular, your leadership and focus on improving the quality and efficiency of the health care system has recognized that Medicare must play a central role to achieve increased transparency and a reimbursement system that is sensitive to performance. We strongly agree.

As participants in the Consumer-Purchaser Disclosure Project we also thank you for the recent opportunity to provide comments on strategies that Medicare can employ to further enhance accountability, reward better performance and improve consumers' ability to make informed decisions. We believe that Medicare can and should continue to support the development of a new generation of consumer-relevant performance measures, report comparative information, and implement performance-sensitive payments. Specific comments and recommendations to advance our shared goal of improving health care performance and transparency were submitted by the Consumer-Purchaser Disclosure Project on June 12, 2006. We join in support of these comments and believe they will help inform your continuing efforts to make Medicare an even more active partner in this vital agenda.

We recognize that much work remains to be done to transform our health care system to one that both measures and rewards proven performance, but, along with you, we are committed to that goal. We hope you will not hesitate to call on our organizations or the Disclosure Project's Co-chairs – Peter Lee at the Pacific Business Group on Health and Debra Ness at the National Partnership for Women & Families– if we can be of any further assistance. Thank you again for your leadership in this important work.

Attachment: List of Endorsing Organizations
June 12, 2006 Comments on S-1488-P

Endorsement of Need to Expand Measurement, Public Reporting and Value Payment

Support for Disclosure Project's June 12, 2006 Comments on Hospital Quality Reporting and Value-based Purchasing and Health Care Information Transparency Initiative
(CMS-1488-P: Changes to the Hospital Inpatient Prospective Payment System)

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American Benefits Council
Center for Medical Consumers
Center for the Study of Services/Consumers' CHECKBOOK
Consumers Union
Employer Health Care Alliance Cooperative
General Electric
Health Policy Corporation of Iowa
HR Policy Association
Midwest Business Group on Health
Motorola
National Business Coalition on Health
National Partnership for Women & Families
National Small Business Association
New Jersey Health Care Quality Institute
Pacific Business Group on Health
Service Employees International Union

June 12, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., NW
Washington, DC 20201

File Code: CMS-1488-P (Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates)

RE: Comments on Medicare Hospital Reporting and Payment Policies:

- Hospital Quality Data;
- Value-Based Purchasing; and
- Health Care Information Transparency Initiative

Dear Dr. McClellan:

Thank you for the opportunity to comment of the proposed changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates. We applaud your efforts to promote and foster increased transparency and we believe that Medicare should lead the way to promoting a market that recognizes and rewards high-quality, efficient, equitable, and patient-centered care. Some overarching comments introduce responses to specific questions on three sections of the proposed rules that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

OVERARCHING COMMENTS

The Federal Government must support the development and endorsement of a robust set of hospital (and other provider) performance measures: Medicare should evaluate the performance of each health care provider that bills Medicare, using nationally-endorsed, scientifically-valid, risk-adjusted, and regularly-updated measures that address:

- Clinical quality (safe, timely, and effective care);
- Efficiency (prices and resource use over time);
- Equity (gender, race, ethnicity); and
- Patient-centeredness.

There is currently a huge need for more nationally endorsed standardized measures in these areas.

Recommended Actions

- HHS or CMS should provide substantial and ongoing funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency, patient-centered/continuum of care, and equity). Developing measures is a public good that requires significant financing from the public sector. Because of

the lack of well-specified and endorsed measures that meet consumers' and purchasers' needs, the federal government should specifically support the rapid development of measures that are:

- Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound and evidence-based, but do not want the pursuit of perfection to delay the availability of good and useful information.
- Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed are currently available or can be collected with limited reporting burden.
- Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
- Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.
- HHS or CMS should provide core ongoing operating support for the National Quality Forum (NQF) to ensure an ongoing, independent consensus process reviews, endorses, and updates measures to enable the availability of comparative information and the reduction of provider reporting burden.

CMS should ensure that measures are reported publicly to foster improvement, accountability and consumers' ability to make better informed decisions. Medicare should provide the public with the information on the aspects of provider performance described above. Doing so, will allow: 1) consumers to make informed decisions about their health care; 2) insurers and purchasers to make value-based contracting decisions and use differential payments as incentives; and 3) providers' improvement efforts to be supported with better information.

Recommended Actions

- CMS should immediately make available physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- CMS should continue to allow private-sector organizations to have full access to provider performance information from the CMS Compare websites.
- CMS should require that hospital claims data submissions be augmented with clinical data elements to enable a better understanding of patient acuity and more robust quality reporting.

CMS should implement financial incentives that are sensitive to the provision of high-quality, efficient, equitable, and patient-centered care: Medicare should phase in a system that differentially pays providers based on nationally standardized measures.

Recommended Actions

- Continue to rapidly expand the number and type of measures that hospitals must report to obtain annual payment update.
- Medicare payments must be sensitive to provider performance and create financial incentives to more efficiently provide higher quality care.
- Incentives should take into account performance on quality, efficiency, equity, and patient experience.
- Provider incentives should be budget-neutral and, in the near-term, based on a combination of improvement and meeting thresholds.

What follow are specific comments on the three sections that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

SECTION: HOSPITAL QUALITY DATA

Reporting of Hospital Quality Data for Annual Hospital Payment Update

Fiscal Year 2007: We support CMS' recommendation to reduce the FY 2007 annual hospital payment update by 2% for any hospital that does not submit data on 21 measures (8 heart attack, 4 heart failure, 7 pneumonia, 2 surgical infection prevention) for patients discharged starting January 1, 2006 through December 31, 2006.

Fiscal Year 2008: CMS must do far more than merely "explore the feasibility of adopting additional measures for FY 2008 update, including HCAHPS." There should be a **substantial** expansion of measures for hospitals to obtain the FY 2008 annual update. We strongly urge that CMS adopt the measures identified in the Institute of Medicine's *Performance Measurement: Accelerating Improvement*, i.e., Hospital-CAHPS and three structural measures (computerized provider order entry, intensive care staffing with intensivists, and evidence-based hospital referral) as well as consider and adopt as many additional NQF-endorsed measures as can be feasibly collected, for example:

Outcomes

- 30-day heart failure mortality
- 30-day heart attack mortality
- Failure to rescue

Complications

- Urinary catheter-associated infection rate
- Central line-associated blood stream infection rate
- Ventilator associated pneumonia rate

Clinical

- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hour prior to surgery to 24 hours after surgery.

Procedures for Validating Hospital Compare Data (pages 337-343): As CMS continues to work to ensure the accuracy of the information posted on the Hospital Compare website, the methodology adopted should be fully transparent to allow all stakeholders to clearly assess hospital-level reliability. CMS should also engage representatives from the research, provider, and consumer communities to obtain input on the different potential methodologies and their impact on data validity, accuracy, and completeness.

Electronic Medical Records (p. 343)

Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. In addition, if appropriately implemented, HIT can and should serve as the platform for the collection of information to supply future performance measurement, reporting and payment systems. The Secretary should ensure that the data necessary for quality measurement are captured by using conditions of participation that require hospitals to implement HIT/software applications that:

- Comply with interoperability standards;
- Adequately protect privacy and confidentiality of patient data;
- Enable standardized quality, performance, and efficiency measurement as a routine by-product of their use; and

- Are designed to enable the merger of their data with others in both the public and private sectors for the purpose of facilitating the production of standardized quality, performance, and efficiency information.

[NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT:
www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]

Further, the Secretary should tie the annual hospital payment update to the reporting of hospitals' progress toward CPOE implementation (see previous comments under Hospital Quality Data for Annual Payment Update).

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

- A unique physician identifier for each coded procedure;
- Capture the referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION: VALUE-BASED PURCHASING

Plan for Implementing Hospital Value-Based Purchasing Beginning with FY 2009

As CMS works to develop a plan to implement hospital value-based purchasing beginning in FY 2009, the following issues must be addressed: (a) the ongoing development, selection, and modification process for hospital quality and efficiency measures; (b) the reporting, collection, and validation of data; (c) the structure of payment adjustments; and (d) the disclosure of hospital performance information.

Measure development and refinement (p.350-353)

As noted in our overarching comments, the development of consumer relevant measures is critical and the Secretary should provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency, patient-centered/continuum of care, and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers' and purchasers' needs, the federal government should specifically support the rapid development of measures that are:

- Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound and evidence based, but do not want the pursuit of perfection to delay the availability of good and useful information.
- Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed are currently available or can be collected with limited reporting burden.
- Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
- Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.

HHS or CMS should provide core operating support for the NQF to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability of comparative information and the reduction of provider reporting burden.

Incentive Methodology (p. 357-367)

Incentive Structure: Incentives should initially be based on a combination of improvement and meeting performance thresholds based on standard measures adhering to the Consumer-Purchaser Disclosure Project's *Guidelines for Measurement of Provider Performance* (<http://healthcaredisclosure.org/docs/files/Guidelines.pdf>). Current experience indicates that shifting over time to basing incentives on attaining specific performance-based thresholds allows hospitals (including those serving disenfranchised populations or unique communities) an opportunity to meet targeted performance levels and focus their efforts on those that would yield the most improvement. Because of the evidence that performance dramatically varies within hospitals, incentives should be available and calculated both at the service-line level (e.g., for specific clinical areas) and hospital-wide (e.g., for H-CAHPS).

Many private sector incentive programs, operated by health plans and other organizations, such as The Leapfrog Group's "Leapfrog Hospital Rewards Program", reward both *top performers* and *performance improvers*. The goal is to provide incentives for hospitals to improve continuously and to sustain that improvement once it is achieved. As Medicare moves to institutionalize performance-based payment, it should consider how to use baseline thresholds of performance and the potential of relative comparisons to help all hospitals make improvements appropriate to their current level of performance.

Level of Incentive: The share of payment tied to performance should be substantial. Clearly what constitutes “substantial” will differ from one type of provider to another (i.e., the same percentage may not be appropriate for both hospitals and physicians). Initially, we believe that the performance incentive for hospitals should be on the same order of magnitude as the level of incentive that rewards public reporting for the FY07 annual market basket update, which is 2% of total Medicare payments. The overall proportion of CMS payments to hospitals that are directly linked to performance should grow significantly over time and could eventually reach a level so that 10% or more of total Medicare payments is sensitive to performance. CMS should set and revise the appropriate level using the information that continues to develop from its implementation of performance-based payments for all hospitals, its demonstration projects, and from private-sector efforts.

Source of Incentive: Performance incentives should be budget neutral. Providing additional funding to finance performance incentives is an unrealistic option given the current economic and cost pressures faced by CMS. One central way to ensure budget-neutrality is to measure and report comparative information and base hospital incentives on efficiency as one of a number of different performance domains.

Development of Composite Scores: The development of composite scores is critical to help consumers integrate complex information into their decision making. Below, we outline additional work that needs to be done around the development and display of composites (see Public Reporting section), but consumer testing should be a key factor in CMS’s assessment of alternative methodologies, i.e., “appropriate care measures” versus the “opportunity model.” [Note: It is our understanding that in initial testing done by Mathematica for CMS in July, 2005, consumers preferred composites based on the appropriate care measure.]

Public Reporting (p. 362)

CMS should further stimulate public reporting to increase the transparency and meaningfulness of health care performance information by taking the following actions:

- Continue to allow private-sector organizations to have full access to provider performance information from the CMS Compare websites.
- Support further research and consumer testing around the development and display of measure composites, including how different tiers of composite scores could be constructed. (E.g., a total, overall score combining clinical quality, patient experience, and efficiency; a score on each of those three respective domains, and a composite by service line, such as diabetes, cardiac care, etc.)
- While improving the utility of the CMS Compare websites through using composites and presentation of providers that shows their differential performance, CMS should maintain the ability for consumers to “drill down” to a granular level of performance detail.

Beyond these suggested actions, we would call your attention to the Principles for Public Reporting of Health Care Information that were developed and endorsed by the members of the AQA (formerly the Ambulatory Care Quality Alliance) as an additional useful reference. These Principles can be found at:

<http://www.ambulatoryqualityalliance.org/files/ConsumerPrinciplesMay06.doc>

Hospital Acquired Infections (p. 363)

Given the tremendous toll – both human and financial – caused by hospital-acquired infections, the Secretary should do more than meet the statutory minimum of identifying “at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.” The Secretary should work with those states that currently collect the “Present on Admission” identifier (e.g., California and Pennsylvania) to determine all those conditions that meet the above criteria and implement policies by which hospitals would have payments adjusted for any care that could have reasonably been prevented in the hospital had evidence-based care been provided.

With the requirement for hospitals to submit the secondary diagnoses that are present on admission for discharges after October 1, 2007, we anticipate much more robust hospital outcomes reporting due to the increased ability to differentiate co-morbidities from complications.

Promoting Effective Use of HIT (p. 364)

Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. In addition, if appropriately implemented, HIT can and should serve as the platform for the collection of information to supply future performance measurement, reporting and payment systems. The Secretary can spur HIT adoption and ensure that the data necessary for quality measures are captured by using conditions of participation that require hospitals to implement HIT/software applications that:

- Comply with interoperability standards;
- Adequately protect privacy and confidentiality of patient data;
- Enable standardized quality, performance, and efficiency measurement as a routine by-product of their use; and
- Are designed to enable the merger of their data with others in both the public and private sectors for the purpose of facilitating the production of standardized quality, performance, and efficiency information.

[NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT:
www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]

Further, the Secretary should tie the annually hospital payment update to the reporting of hospitals’ progress toward CPOE implementation (see previous comments under Hospital Quality Data for Annual Payment Update).

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

- A unique physician identifier for each coded procedure;
- Capture the referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION: HEALTH CARE INFORMATION TRANSPARENCY INITIATIVE

As the Department builds upon its current transparency efforts, we would encourage the Secretary to increase both the scope and breadth of consumer-friendly cost and quality information by employing the following strategies. The critical need to directly link, wherever possible, consumers' cost information with quality information reinforces the importance of the federal government supporting the development and endorsement of a robust set of hospital (and other provider) performance measures (see "Overarching Comments").

Actions the federal government should take to increase the breadth and scope of performance information available to the public include:

- Making available physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Continue to allow private-sector organizations to have full access to provider performance information from the CMS Compare websites.
- Release the risk-adjusted DRG rates for every hospital (and rates for physicians), by region in easily accessible formats.
- Develop BOTH total costs of episodes AND total estimated beneficiary out-of-pocket costs for episodes of care (with estimates for beneficiaries with and without Medigap supplemental coverage). This release should include contextual and background information that makes clear the relevance of Medicare costs to beneficiaries to their circumstance (e.g., having Medigap plan) or to commercially insured individuals.
- Price information should be presented in a manner that reflects the following principles:
 - **Linked directly to Quality measures** (outcomes, patient experience, compliance with evidence-based medicine). Whenever possible price information should be directly linked to quality information to facilitate total value consideration by the consumer. When it cannot be, there should be context and background (including that price does not correlate to quality, i.e., more expensive does not mean better and less expensive does not mean worse).
 - **Understandable**: Information should be "transmissible", that is, it can be communicated from one consumer to another and must recognize that different consumer audiences will have different information seeking and comprehension skills.
 - **Actionable**: Information should include relevant comparisons of providers based on quality and cost; link to a consumer being able to select a particular option; and should provide context and background on how to not just compare price of providers/treatments selected, but information on potentially relevant alternatives.
 - **Accessible**: Should be available on-line with no barriers and designed for ease of use.
 - **Relevant to consumers' circumstances** (health and coverage status): Information should be useful in the context of an individual's or family's particular health coverage and health status (including potentially a discrete condition OR considering a combination of conditions).
 - **Predictive (accurate)**: Information should predict likely expense accurately and/or have clear explanation of the reason for range of cost variation.

CMS/HHS should consider using the following mechanisms to further enhance transparency of quality and cost information by:

- Establishing conditions of participation for hospitals that require posting of prices and/or policies regarding discounts and other payment options for uninsured patients. For insured individuals, health plans will likely be the primary vehicle for information that is specific to their condition or coverage, but CMS should play a

central role in ensuring that the uninsured have access to information relevant to their circumstances, though true transparency and informed consumer decision-making will require actionable tools.


- The Administration through its various contracting mechanisms with health plans (via OPM or Medicare), should ensure they are providing tools for enrollees to make informed choices, considering both quality and costs.
- Requiring hospitals to augment claims form with additional clinical data elements. Accurately assessing provider performance would be greatly enhanced if the severity of the patient's condition could be captured from administrative claims data. The public reporting of quality and cost information would benefit greatly from claims data with richer detail. Adding the following data elements to the inpatient paper and electronic claim form would enable much more robust hospital outcomes reporting:
 - A unique physician identifier for each coded procedure;
 - Capture the referring/ordering physician for each coded procedure;
 - Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
 - Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
 - Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
 - Time of day of admission, discharge, and each procedure.

Again, thank you for the opportunity to comment.

Sincerely,



Peter V. Lee
Disclosure Project Co-Chair
Chief Executive Officer
Pacific Business Group on Health



Debra L. Ness
Disclosure Project Co-Chair
President
National Partnership for Women & Families