Consumer-Purchaser
DISCLOSURE PROJECT
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January 13, 2012

Cynthia Tudor, Ph.D.
Director
Medicare Drug Benefit and C&D Data Group
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Dr. Tudor:

The Consumer-Purchaser Disclosure Project (CPDP) is a coalition of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information. Our shared vision is that with this information, Americans will be better able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency. We appreciate the opportunity to provide pre-rulemaking input on the Medicare Advantage Quality Bonus Payment (MA QBP) program, and the star rating system used on the Medicare Plan Finder website. We strongly support the direction that CMS is proposing, namely, to expand the star rating system beyond the current set of health plan-level measures to include clinical quality measures at the hospital and provider level.

The original intent of the Medicare Advantage (MA) program was to provide an option for Medicare beneficiaries to enroll in private plans that could operate more efficiently than traditional Medicare fee-for-service. For many years the MA program has neglected to pursue this intent, providing MA plans with payments that far exceed comparable costs in traditional fee-for-service Medicare and failing to drive plans to pursue high-quality, high-value care. In the Affordable Care Act, Congress sought to remedy this through a number of changes, including the enactment of the QBP program. CMS must leverage these bonuses to enable health plans to vigorously address disparities and inefficiencies in care for Medicare Advantage beneficiaries. In addition, as more money is being put into this program, there needs to be a greater emphasis on simplifying the way information on plans' quality is provided to consumers so that they can effectively use it to make informed decisions about their Medicare Advantage plan choices. Our comments below identify the measures in the Inpatient Quality Reporting program that we believe would satisfy both of these criteria.

Overall, we strongly believe that the Medicare Advantage QBP program should align – in spirit, as well as in in specific measures to the greatest extent feasible – with the efforts that we are advocating states to pursue in their development of the Health Insurance Exchange consumer assistance tools, and the web portals in particular. In both the MA QBP and the Exchanges, there are myriad opportunities to design systems in such a way that drives improvements in quality of care as well as reduces costs across the entire system. To achieve this vision, consumers must be engaged in the conversation, and engagement requires being equipped with robust information on quality and costs. Currently, even in locations where there are 4- and 5-star Medicare Advantage plans operating, the evidence shows that Medicare beneficiaries are not choosing them; that instead of making decisions based on value, they are choosing plans on cost alone (with no reference to quality), and on access to their doctors.

www.healthcaredisclosure.org

Pacific Business Group on Health
221 Main Street, Suite 1500, San Francisco, CA 94105
415.281.8660 | tel

National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650, Washington, DC 20009
202.986.2600 | tel

While access and cost are undoubtedly important data points, we urge CMS to take an active role in informing beneficiaries about the importance of quality linked with cost by both providing the context (e.g., what quality care means and the role that patients, providers, and plans can play in creating a high-quality, high-performing health care system) and reporting it alongside the cost information. Adding measures of clinical performance will help move the Medicare Plan Finder website in this direction, with CMS taking a lead role in requiring greater information and transparency from which to support this type of engagement. Our ultimate goal is for Medicare Advantage to not only provide affordable, high quality coverage, but to contribute to the overall system transformation that the Affordable Care Act and other programs and initiatives were designed to achieve.

Our comments below identify which measures currently finalized in the Inpatient Quality Reporting (IQR) Program, as well as measures listed in this Request for Comments, we believe will add the greatest value to the program.

Inpatient Quality Reporting (IQR) Program Measures

We urge CMS to send a strong signal about the importance of focusing on measures of outcomes and patient safety by committing to adding the following finalized IQR measures in the QBP program:

- Hospital Consumer Assessment of Healthcare Providers and Systems Survey
- Central-Line Associated Blood Stream Infection (CLABSI)
- Surgical Site Infection (SSI)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- 30-day Risk Adjusted Mortality Rates for AMI, HF, and Pneumonia
- 30-day Risk Adjusted Readmission Rates for AMI, HF, and Pneumonia
- Agency for Healthcare Research and Quality Patient Safety (PSI) and Internal Quality (IQI) Indicators:
  - PSI 4: Death Among Surgical Patients with Serious, Treatable Complications
  - PSI 6: Iatrogenic Pneumothorax
  - PSI 11: Post-Operative Respiratory Failure
  - PSI 12: Post-Operative Pulmonary Embolism or Deep Vein Thrombosis
  - PSI 14: Post-Operative Wound Dehiscence
  - PSI 15: Accidental Puncture or Laceration
  - PSI 90: Complication/Patient Safety for Selected Indicators Composite
  - IQI 19: Hip Fracture Mortality Rate
  - IQI 91: Mortality for Selected Medical Conditions Composite

All of the above measures provide critical information on outcomes, patient experience, and patient safety. Their use in the MA QBP will help to drive alignment between the Medicare Advantage Star Rating system and other CMS initiatives, including the Partnership for Patients and the progress toward meeting the goals set in the 2009 HHS Report "*An Action Plan to Reduce Hospital-Acquired Infections."* These measures also align with the goals and strategies set out in the *National Quality Strategy,* as well meet the evaluation criteria used by the *Measure Applications Partnership,* a multi-stakeholder consultative body created to provide input to the Secretary of HHS on which measures to use in public reporting and payment programs.

We strongly suggest that CMS not include in the proposed Medicare Advantage rule the myriad process measures currently finalized in the IQR. While – in some cases -- these measures have had an effect on internal quality improvement and overall quality of care, they are decidedly not meaningful for consumer decision-making, and will not help CMS fulfill the promise of this expanded QBP program. We urge CMS to be mindful of the difference in how consumers use the Medicare Plan Finder website versus the IQR/Hospital Compare website, and focus solely on measures, such as the ones listed above, that truly speak to consumers, and not to internal quality improvement processes.

Additional Quality Measures

We strongly support the addition to the QBP of the other measures that CMS lists in the Request for Comment, including the following:

- **Survey measures of care coordination from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (part C)** including all questions listed in the RfC:
  - *Whether doctor had medical records and other information about the enrollee's care,*
  - *Whether there was follow up with the patient to provide test results,*
  - *How quickly the enrollee got the test results,*
  - *Whether the doctor spoke to the enrollee about prescription medicines,*
  - *Whether the enrollee received help managing care, and*
  - *Whether the personal doctor is informed and up-to-date about specialist care.*

  The strengthening of the CAHPS survey via the addition of questions specifically targeting the fragility of the care coordination and care transition experience for Medicare beneficiaries will be tremendously valuable, and having those data publicly reported through the star rating system will make the program not only more useful to beneficiaries, but once again highlight CMS' role as a leading purchaser of care, demonstrating a deep understanding of the critical nature of patient-reported data and patient experience measures.

- **Medication Therapy Management (MTM) program measures related to Comprehensive Medication Reviews (Part D).** Without more information on the MTM measure (such as the name of the developer or the exact specifications) endorsed by the Pharmacy Quality Alliance, we are unable to voice our clear support for or against its implementation in the QBP. However, based on the description in the Request for Comments, we can say with confidence that the direction of this measure is appropriate and meaningful for the QBP program, as it relates to quality, medication management and error avoidance, and care coordination. We request that CMS provide more detail on this measure when the proposed rule is made available for public comment.

- **Measure of Quality Improvement (Part C and D).** The Request for Comment states that a measure of quality improvement at the individual measure level will be created to determine changes in quality, as a step toward measuring net improvement at the contract level. As with the MTM measure above, we are directionally very supportive of this effort, and look forward to seeing additional information provided in the proposed rule. Overall, data that signals an increase or decrease in quality over time will be extremely useful to consumers as they seek information from which to make crucial health plan purchasing decisions.

Other Changes to Methodology

We appreciate the direction CMS is seeking to move in with the changes in methodology listed in this section and want to highlight the following as initiatives/efforts for which we are particularly supportive:

- High-Risk Medication Measure (part D)
- Pharmacy Adherence (ADH) Measures (Part D)
- Plan Makes Timely Decisions About Appeals (Part C)
- Call Center – Foreign Language Interpreter and TTY/TDD Availability (Part C and D)
- Enrollment Timeliness (Part C and D)
- Beneficiary Access and Performance Problems (Part C and D).

All of the above measures correspond to important elements in the National Quality Strategy – including safety, appropriateness of care, and access to care to improve population health – as well as promote alignment with other measures of consumer satisfaction and experience such as those that consumer and purchaser representatives are supportive of in the Health Insurance Exchanges.

Additional Measures to Consider

As CMS collects input from the range of stakeholders on Medicare Advantage's QBP Program, we wish to offer additional measures to consider for implementation in the program:

- **American College of Surgeons (ACS) National Surgical Quality Improvement Program (ACS NSQIP) outcome measures**[1]. This program measures actual hospital results 30 days-postoperatively (including mortality) on a number of surgical procedures.
- **University of California San Francisco paired ICU measures "Intensive care unit length-of-stay" and "Intensive care: In-hospital mortality rate."** These measures are currently in widespread use in California and are being reported through the California Hospital Assessment and Reporting Taskforce (CHART) website.
- **HEDIS Measures of Relative Resource Use**. The HEDIS RRU measures provide important information to both consumers and providers on appropriate use of care at various setting levels.
- **Minnesota Community Measurement's Depression Outcome Measures, Remission at 6 months; and Remission at 12 months.** Depression is one of the top 10 high-impact conditions that NQF identified for the Medicare population, through a CMS-funded project in 2010.
- **Measures of Care for Dementia Patients**. The existing measure in the QBP on "Percent of Plan Members who Maintained or Improved their Mental Health" falls short of providing useful information for either consumers or providers, given the growing volume of elderly consumers are being diagnosed with dementia. We strongly urge CMS to develop a specific measure of whether, during at least one annual visit, the patient received a dementia screening, along with any necessary follow-up care plan. This measure would support the Affordable Care Act's annual wellness visit for Medicare beneficiaries, for which a required component is an assessment of cognitive impairment.

On behalf of the Consumer-Purchaser Disclosure Project, we appreciate the opportunity to provide these comments on the Medicare Advantage star rating system and Quality Bonus Payment program. Please feel free to contact either of us if you have any questions.

Sincerely,

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

William Kramer
Executive Director for National Health Policy
Pacific Business Group on Health
Co-Chair
Consumer-Purchaser Disclosure Project

[1] Case Study: The National Surgical Quality Improvement Program, Commonwealth Fund, May 2005, http://www.commonwealthfund.org/Content/Innovations/Case-Studies/2005/May/Case-Study--The-National-Surgical-Quality-Improvement-Program.aspx