



Administrator

Washington, DC 20201

JUN 24 2005

The Honorable William M. Thomas
Chairman
Committee on Ways and Means
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter in which you seek our assistance in moving the Medicare program toward value-based purchasing. We share your goal of providing payments that help reshape the way we deliver health care in this country to provide better support for greater quality and fewer unnecessary costs, and improved health. We are committed to working with the Congress, the provider community, and other stakeholders to develop reporting and payment systems that enable us to support and reward quality.

At present, the Medicare program uses eleven different fee schedules or prospective payment systems to pay claims for services from over one million health care providers. As you mentioned, these fee-for-service payment systems pay physicians and other health care providers based on the number and complexity of services provided to beneficiaries, regardless of their quality, efficiency, or impact on health outcomes.

As a result, our payment systems often have the effect of directing more resources to delivering care that is not of the highest quality, such as duplicative tests and services, as well as hospital admissions or visits to treat potentially avoidable complications. Conversely, providers who have good ideas and want to take action to improve quality of care find that Medicare's payment systems do not provide them with the resources or the flexibility needed to do so. As a result, providers are unable to invest in activities that, properly implemented, have the potential to improve quality and avoid unnecessary medical costs. Such activities could include patient help lines, health information technology (HIT) systems that help patients with chronic diseases understand how they can prevent complications that result in costly hospitalizations and doctor visits, or reminder systems for using preventive services. Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give providers more direct incentives and financial support to implement the innovative ideas and approaches that actually result in improvements in the value of care that our beneficiaries receive.

In his FY 2006 Budget, the President recognized the need for payment reforms to improve the value of care delivered to Medicare beneficiaries. Such reforms would build on the action the Administration has already taken to promote quality by using data from Medicare providers to construct publicly available measures. The Medicare Payment Advisory Commission (MedPAC) also offered several recommendations in its March 2005 Report to Congress to

promote value-based purchasing. We generally support MedPAC's goals in this area, and we are working actively with many outside organizations, particularly in provider-led efforts, to achieve higher quality and better use of resources.

Please find below summary responses to each of the questions you raised in your recent letter. Where applicable, we have also attached additional, more detailed material.

Development of Quality Indicators. The foundation of effective pay-for-performance initiatives is collaboration with providers and other stakeholders, to ensure that valid quality measures are used, that providers are not being pulled in conflicting directions, and that providers have support for achieving actual improvement. Consequently, to develop and implement these initiatives, CMS is collaborating with a wide range of health care providers, other public agencies, and private organizations who share our goal of improving quality and avoiding unnecessary health care costs. Enclosure 1 provides more detail about our efforts to work with hospitals, skilled nursing facilities, home health agencies, end stage renal disease (ESRD) facilities, and physicians to develop measures.

The healthcare community has already exhibited leadership and interest in quality measurement, public reporting, and paying for performance. We have heard repeatedly from individual providers and provider organizations around the country about their desire to support the development and implementation of appropriate measures and payment methods and to participate in well-designed initiatives in this area. We will continue to work with health care providers and Medicare beneficiaries to make further progress on these efforts.

To date, we have worked with the Hospital Quality Alliance (HQA) in the selection of a starter set of ten consensus-derived hospital performance measures for public reporting. Consensus around these measures was achieved because these measures are widely viewed as meaningful elements of quality, they are clinically valid, and they are feasible and not too costly to collect. These are the same measures that were established under section 1886(b)(3)(B)(vii)(II) of the Social Security Act, as added by section 501(b) of the Medicare Modernization Act (MMA). It is important to note that most hospitals are already reporting a larger set of clinical quality measures than were required by the MMA, and that we expect to expand these measures further in the coming year to include standardized measures of quality from the beneficiary's perspective and outcome measures, such as those related to post-surgical complications.

CMS has also been working closely with consumer groups and nursing home leaders through the Nursing Home Quality Initiative, a collaborative effort to improve quality of care in nursing homes. A key element of this effort is the development and improvement of specific quality measures. Currently, we publicly report 15 measures of nursing home services that are submitted by facilities via the Minimum Data Set (MDS). The quality measures were endorsed by the consensus process of the National Quality Forum (NQF). The nursing home industry, patient advocacy groups, and other stakeholders are working with us to improve these measures, while we build a more robust set of measures. For example, in our recent proposed rule for

payment of skilled nursing facilities, we sought comment on additional quality measures and the design of incentives for superior performance. In fact, we are collaborating to assess and develop possible pay-for-performance models, and have recently contracted with Abt Associates to develop a potential demonstration project in this area.

CMS has also been collaborating with provider groups and other stakeholders involved in home health care and care for patients with end stage renal disease. In the home health care setting, CMS now receives quality data regarding the status of a patient's physical and mental health, maintenance or improvement in the patient's ability to perform basic daily activities, and patient medical emergencies. The home health measures are based on information collected on Medicare or Medicaid patients who receive care at a Medicare certified home health agency. For dialysis facilities, CMS's Clinical Performance Measures (CPM) Project currently monitors 16 quality measures that report the quality of dialysis services in three areas: the adequacy of hemodialysis and peritoneal dialysis; anemia management; and vascular access management. In addition, CMS currently collects data on patient nutrition, and is developing additional measures related to kidney transplant referral and end stage renal disease bone metabolism.

We have also made substantial progress with physician groups and other stakeholders on the development and use of measures for physician-related services. Measures of the quality of ambulatory care have been identified through collaboration between CMS, the American Medical Association's Physician Consortium for Performance Improvement, and the National Committee for Quality Assurance (NCQA). This collaboration resulted in a set of proposed measures that are currently being considered for endorsement by the NQF. As part of the Ambulatory care Quality Alliance (AQA), CMS and other stakeholders, including the American College of Physicians, the American Academy of Family Practice, and other physician groups, as well as representatives of private health plans, selected a subset of these measures as a starter set for implementation. These measures cover diabetes, heart disease, asthma, and preventive screening. These measures are already in use in an ongoing Medicare demonstration project.

The entire starter set of ambulatory care measures are now in the final stages of endorsement. These measures are designed to reflect performance in primary care and may also apply to some specialists as well, insofar as specialists are involved in the furnishing of primary care to patients with common chronic diseases, including diabetes and heart disease. In addition, measures of effectiveness and safety of some surgical care have been developed through collaborative programs like the Surgical Care Improvement Program, which includes the American College of Surgeons. We are also collaborating with many specialty societies to develop quality measures that reflect important aspects of the care of specialists and sub-specialists. For example, we are working closely with oncologists to develop measures of the adequacy of treatment planning and follow-up that oncologists furnish as part of their evaluation and management services; with cardiologists on measures of cardiac care for heart attack or heart failure conditions; and with cardiovascular surgeons on measures related to cardiac surgery.

While these collaborative processes have already resulted in clinically valid quality measures for many physician specialties, some specialty societies report that they are still in the development stage, and a few are not reporting any activity. The progress of many specialties to date clearly indicates broad interest, from CMS and other key stakeholders and consensus groups like the

NQF, to support the efforts of specialty societies to develop and refine their measures. As we have indicated, we are pleased to work with any medical specialty to support their quality measurement and improvement efforts. Enclosure 2 provides a list by specialty of the types of quality measures that have been developed or are under development. A preliminary assessment indicates that the specialties for which some measures have been developed account for about half of Medicare physician spending. Specialties accounting for another 40 percent of physician spending have measures under development.

In addition, virtually all specialties have noted that evidence-based guidelines for best practices have been developed for many important aspects of the care they provide. Such guidelines do not apply to all patients receiving care from a particular specialty, but they do generally reflect the state of medical evidence about what works best in the specialty for many of the common problems they treat. Some have suggested that, while they work to develop more specific clinical quality measures, a useful interim indicator is physician reporting on whether a relevant practice guideline was followed for the care of a patient (and possibly, a reason for not following a relevant guideline). A number of private-sector efforts are implementing such approaches now with the goal of improving quality, with some promising results. Such data also help identify circumstances where better medical evidence is needed to help improve practices, another key step for achieving quality improvement. In addition, there is some evidence that compliance with such guidelines may lead not only to better quality but also to better use of resources.

We are exploring methods of reporting physician quality measures through claims and other methods. Many measures with clinical aspects can be reported through existing data systems. For example, in the current oncology demonstration project, physicians are assessing the symptoms of Medicare beneficiaries who are receiving chemotherapy using validated, widely accepted symptom questionnaires that focus on nausea and vomiting, pain, and fatigue. The physicians participating in the demonstration project report on the patients' symptoms via the existing Medicare claims system. Such a reporting mechanism could potentially be used for other specialties, whether for reporting patient symptoms, or for reporting on evidence-based practices that enhance the quality of care.

Systems for Reporting and Analyzing Quality Indicators. Implementing measures in a pay-for-performance system will require infrastructure that can obtain appropriate information from providers, store and aggregate it as necessary, and prepare it for use in payment systems. Over the past few years, CMS has developed an infrastructure that can serve to collect data for quality measurement purposes via secure channels for its submission, storage, analysis, validation, and reporting. The consistent construction and analysis of hospital quality measures based on reported quality data from nearly all hospitals illustrates the key aspects of such systems. Similar tools can be applied in other settings, such as ambulatory care.

To submit data on quality measures, hospitals employ either Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Performance Measurement System vendors or the CMS Abstraction and Reporting Tool (CART). CART is a broadly-applicable software tool that providers and their designees can use to abstract clinical data needed for quality measures from medical records. This tool was designed and developed by CMS with input from JCAHO and the Quality Improvement Organizations.

CMS has also developed a system for secure, HIPAA-compliant transmission of clinical quality data on hospital care for the consistent construction and validation of quality measures. Hospital data is submitted via QNet Exchange—the CMS-approved electronic system for secure communications and data exchange—to a national data repository for private healthcare data. Currently this repository contains information on the ten measures collected pursuant to section 501(b) of the MMA plus the growing number of additional measures collected under the Hospital Quality Alliance Initiative. Data can be submitted at any time throughout the year, but there is a deadline for submission of each quarter's hospital discharges.

After the data are received in a valid format, the measures are calculated by editing the data against appropriate logic to assure valid measure development. This logic, specified by a diverse group of Federal and non-government clinical experts, includes medical procedure and condition codes, exclusion criteria, and other empirically based measure-specific rules. Data submitted by hospitals are also validated through independent abstraction of medical records by a CMS contractor, the Clinical Data Abstraction Center. Hospitals have an opportunity to review the results for 30 days before they are posted.

Size of Incentives Needed to Encourage Reporting. The experience with section 501(b) of the MMA and other programs suggests that limited adjustments in payment rates may be sufficient incentive to encourage providers to perform well on measured aspects of performance. Section 1886(b)(3)(B)(vii)(II) of the Social Security Act, which was added by section 501(b) of the MMA, requires a 0.4 percentage point higher payment update for acute care hospitals that submit information on ten measures of quality for each of fiscal years 2005, 2006, and 2007. If a hospital provides the information by a specific date in the prior year, the full update applies to all inpatient discharges from that hospital during a subsequent fiscal year. Nearly every eligible hospital in the country was willing and able to submit the required data in order to qualify for full update—a clear indication that well-defined incentives can bring about appropriate system change.

Further, CMS has partnered with Premier Inc., a nationwide alliance of not-for-profit hospitals, to conduct a demonstration program designed to improve the quality of inpatient care for Medicare beneficiaries by providing financial incentives. Payment adjustments under the demonstration will be provided to hospitals scoring in the top 20 percent for a given set of quality measures—an additional 2 percent on top of the normal DRG payment will be made to hospitals scoring in the top 10 percent, and an additional 1 percent payment will be made to hospitals in the next highest 10 percent. In the third year of the demonstration, hospitals that do not achieve significant absolute improvements above the demonstration baseline will be subject to reductions in payments. Preliminary results released in May show that these modest payment adjustments are sufficient to drive quality improvement. This project further validates the fact that payment incentives are bringing about real, meaningful change. We are encouraged by these early results and are using this effort to begin laying the foundation for a pay for quality program for all hospitals.

The Physician Group Practice Demonstration project presents another example. This project is designed to test pay-for-performance in Medicare's fee-for-service payment system for physicians. The project is assessing the ability of ten large, multi-specialty physician groups to

improve care that could result in better patient outcomes and efficiencies. Participating physician groups will continue to be paid on a fee-for-service basis, but they are earning performance-based payments of up to several percent (up to 5 percent of their performance target) for implementing care management strategies that anticipate patients' needs, prevent chronic disease complications, avoid hospitalizations, and improve the quality of care. The performance payment will be derived from savings in total Medicare benefits achieved by the physician group for its patient population and paid out in part based on the quality results.

CMS is also designing a pay-for-performance demonstration project to improve the quality and efficiency of care for chronically ill Medicare beneficiaries treated in small- and medium-sized physician practices, by providing assistance in adopting and using effective health information technology. The Medicare Care Management Performance Demonstration project will provide quality reporting and performance payments to physicians who meet or exceed performance standards in clinical delivery systems and patient outcomes, and will reflect the special circumstances of smaller practices. This demonstration is under development and will be implemented in Arkansas, California, Massachusetts, and Utah. Participating practices will receive technical assistance from the Quality Improvement Organizations in their areas, as well as bonus payments for achieving the project's objectives.

Resource Use. Measures of physician resource use have been used and are being developed by a number of public and private entities. In its March 2005 Report to Congress, MedPAC recommended that the "Secretary should use Medicare claims data to measure fee-for-service physicians' resource use and share results with physicians confidentially to educate them about how they compare with aggregated peer performance." CMS is preparing to implement the MedPAC recommendation in the near future on a pilot basis, using information derived from claims data. We are using existing claims data to simulate and test the measurement and quantification of individual physician patterns of practice, incorporating both services they order (including facility services) as well as services they furnish. As a next step, soon we expect to begin sharing the results with physicians confidentially to educate them about how they compare to peers.

CMS Demonstrations. As I have noted above and also as we have described in more detail in Enclosure 3, we are conducting a number of demonstrations and piloting various payment reforms to reward providers for better quality, better patient satisfaction, and lower overall health care costs in the Medicare fee-for-service program. Building on these initiatives, we recognize that many of the best opportunities for quality improvement cut across settings of care. We have projects in operation or in the advanced planning stages in the fee-for-service sector that will use standard quality measures to support better care coordination and continuity for beneficiaries with chronic illnesses across different care settings. In the Medicare Advantage program, we are moving toward full risk adjustment, which provides more resources to health plans that are able to attract and retain high-cost beneficiaries, thus providing stronger incentives to improve continuity and quality of care, while avoiding unnecessary services. In conjunction with these changes, we are seeing more efforts by Medicare Advantage plans to provide greater continuity of care and support for beneficiaries with predictably high costs, as well as more use of performance-based payments.

We want to build on all of these steps to give providers the support and resources they need to deliver better care and avoid unnecessary costs. Linking a portion of Medicare payments to valid measures of quality, using the kinds of approaches summarized here, would support better health care. These direct incentives would foster the development and implementation of innovative ideas and approaches that will result in improvements in the health care that our beneficiaries receive.

As evidenced by the early work of some of our demonstration projects, and the leadership Congress provided in the MMA creating incentives for hospital reporting, we are seeing meaningful results. These results are a promising foundation to support the most effective clinical and financial approaches to achieve better health outcomes for Medicare beneficiaries. We look forward to continuing to work closely with you and all of our stakeholders to advance these important initiatives to improve quality and avoid unnecessary costs for Medicare beneficiaries and throughout our health care system. I also will provide this response to the cosigner of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark McClellan", with a long horizontal flourish extending to the right.

Mark B. McClellan, M.D., Ph.D.