January 10, 2014

Marilyn Tavenner, Administrator
Center for Medicare & Medicaid Services
7500 Security Blvd.,
Baltimore, MD

Dear Administrator Tavenner:

Thank you for the opportunity to comment on the draft CMS Quality Strategy. We strongly support this vital effort and provide the following thoughts.

Outcomes and Process Measures: Stakeholders understandably clamor for more outcome measures to know the ultimate value of care, better illuminate quality concerns and spur innovative solutions that engage providers as well as patients and communities. However, outcomes for many conditions can occur in small numbers, or only after significant time, which does not provide a stable or actionable picture of performance. Factors other than medical care can also impact health outcomes. For example, cancer mortality correlates with underlying disease biology and hospital readmissions correlate with socioeconomic status.

Structure and process measures are often dismissed as “check-the-box” measures that do not assess what matters most. However, where a process clearly results in better outcomes, S&P measures are a direct way to improve quality.

Patient-reported outcome measures have long been used in clinical research and are being introduced in some care delivery areas. For accountability we need patients to report symptoms and functioning so we can use this information to better understand what improvements can be achieved in diverse populations. This requires new data sources, new patient and provider roles, and investing in methods for understanding how to use patient-reported information both for care and to assess quality fairly. We urge you to continue to support development of these measures so they can be used for performance measurement.

Payment Reform: Getting better value – more health for the health care dollar – requires work on many fronts, starting with payment reform. Performance measurement yields impressive improvements over time, especially when combined with pay-for-performance incentives. The Medicare Advantage Star Ratings provide a clear illustration, where the Affordable Care Act’s P4P program has created unparalleled interest in improvement from plans that previously dismissed quality concerns. After little change for years on key HEDIS measures, rates have risen from 77.9 to 81.5% on smoking cessation advice, from 36.6 to 62.2% on adult BMI assessment and from 41 to 55.2% on colorectal cancer screening. We believe these positive trends will continue.
Unfortunately, incentives for high performance measurement are often dwarfed by overvalued payments. For example, hypertension and cholesterol control are among the most efficient and effective ways to prevent heart attacks and strokes, easy to measure and a common P4P focus. The incentives, however, are often much less than profits from lucrative stents and catheterizations. We urge you to continue your efforts to improve payment accuracy and to begin also basing payment on a service’s value in improving health, not just the cost of providing it.

Better Evidence: Although we recognize that generating new clinical evidence is largely outside CMS’s scope of responsibilities, we cannot overemphasize that this is critical for improving both performance measurement and care outcomes. Evidence from most randomized clinical trials is from non-elderly adults who may have different biological processes than the elderly or children. Many measures thus exclude populations over or under a certain age where there is no clear evidence about efficacy. For many aspects of care – particularly within specialty care – we lack strong scientific evidence or guidance applicable to sufficiently broad populations needed to support standardized measures.

Thank you again for the opportunity to comment on your draft Quality Strategy. We look forward to working together with you to advance this important agenda.

Sincerely,

Margaret E. O’Kane
President

---