



May 14, 2009

Senator Max Baucus, Chairman  
Senator Chuck Grassley, Ranking Minority Member  
U.S. Senate  
Committee on Finance  
Washington, D.C. 20510

Dear Chairman Baucus and Senator Grassley:

The National Committee for Quality Assurance (NCQA) appreciates the opportunity to provide comments on the Senate Finance Committee's policy options for health care delivery system reform. We applaud your leadership in this area and especially appreciate your continued focus on ways to improve the quality of care delivered to all Americans. NCQA believes comprehensive reform is needed to make care more accessible, affordable and accountable.

The Committee's policy options paper contains many excellent ideas to advance a value-based health care system. We especially want to praise the inclusion of proposals to move Medicare payment systems from a fee-for-service approach towards a system with financial incentives for high-quality, efficient care. Current payment systems fail to encourage better performance and, in many cases, provide the wrong incentives to the best care. By moving to a system that pays health care professionals and organizations based on how well they deliver care to patients, Medicare can set an example for the entire health care system.

We also appreciate the proposals to expand the scope of health care quality measurement and to involve key stakeholders in the process of establishing and following national priorities. NCQA has been a leader of the collaborative National Priorities Partnership (NPP) to identify key areas for further research and measure development. The work of the NPP and its 28 diverse members must be carried forward if it is to achieve the promise of better care. We look forward to working with you and the leaders of the Senate Committee on Health, Education, Labor and Pensions on ways to continue and expand this work.

Following are NCQA's specific comments on several of the areas covered by the Committee's options paper.

### **Physician Quality Reporting Initiative (PQRI) Improvements and Requirements.**

NCQA strongly supports the proposal to extend the PQRI program and to continue to provide incentive payments to those health care professionals who participate. Ultimately, we believe PQRI must transition from a pay-for-reporting approach to a pay-for-performance system. As such, we support the Committee's ideas to transition from a "carrot" style rewards program to a "stick" style penalty for those who do not participate in 2011.

We note the Committee's proposal to include participation and completion of a Maintenance of Certification (MOC) as an option for qualifying for PQRI incentive payments. We support this expansion of criteria and urge the Committee to provide the same two-year qualification approach to those physicians who utilize a measure group registry such as NCQA's Diabetes Physician Recognition Program (DPRP) and Back Pain Recognition Program (BPRP). NCQA Recognized Physicians demonstrate that they are consistently performing at levels meeting high quality standards that should qualify them for PQRI incentive payments for two years.

Finally, the Committee notes that the Centers for Medicare & Medicaid Services (CMS) is required to report to Congress with a plan to transition PQRI to a pay-for-performance system. We urge the Committee to ask CMS to include a data validation strategy, continued consideration of using data from different sources and, most importantly, to consider how PQRI requirements can align with the "measures of meaningful use" requirements for health information technology under the American Recovery and Reinvestment Act of 2009.

### **Medicare Advantage – Options to Promote Quality, Efficiency and Care Management.**

NCQA strongly supports the Committee's proposals to improve quality, efficiency and care management in the Medicare Advantage (MA) program. NCQA is proud of the role we have played in making the MA program one of the most transparent and accountable segments of the Medicare program. For nearly 12 years, we have collected HEDIS® data from MA plans. In recent years, Congress has extended those reporting requirements to new types of plans including Private Fee for Service (PFFS) plans. We have been pleased to see the progress that MA plans have made in improving the quality of care for their members. In recent years, however, that progress has slowed and in the past two years has been negligible. This trend needs to be addressed and we believe the Committee's proposals are an excellent start. By tying a portion of Medicare's payment to the performance of a plan on a group of clinical and patient experience measures, CMS can begin to drive a new wave of quality improvement for this critical population. We urge the Committee to apply this approach to all MA plans. In addition PFFS and PPO plans are not yet being held to the same standard as other MA plans, as they are required to report only on care provided by network providers (unlike HMO plans that are accountable for all care). Since some of these plans (PFFS) have no network providers, there would continue to be no information about quality of care provided by these plans. We ask the Committee to address this loophole.

### **Improving Quality Measurement.**

We are also supportive of the Committee's proposals to improve quality measurement. Since we began developing and collecting HEDIS measures nearly 20 years ago, the field of health care quality measurement has grown and is now part of the mainstream of health care delivery in the U.S. Yet there are tremendous gaps in the evidence base on which measures are derived and on the set of measures in use today. We think the proposed approach to evaluating adherence to appropriateness criteria for imaging has the potential to make an important contribution to improving quality, safety and affordability in a key area of health care. We applaud the Committee for taking this step, which is consistent with the recommendations of the National Priorities Partnership.

### **Medicare Shared Savings Program (i.e. Accountable Care Organizations).**

NCQA strongly supports the idea of allowing groups of providers who voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. This can be an important incentive for

quality performance and improvement. An important feature of such a policy would be the use of a standardized set of quality measures for all such organizations that have strong stakeholder input and support. We agree with the proposed qualification criteria for the program, which we think are necessary and feasible.

### **Payment for Transitional Care Activities.**

We agree with the Committee that transitional care is a very important area for quality improvement. Based on our work evaluating Patient-Centered Medical Homes we have found a weak point in this process is the flow of information from the hospital to the physician about physicians' patients. As part of this initiative, CMS should work with hospitals to support physicians in providing care at this key time.

### **CMS Chronic Care Management Innovation Center.**

We very much support the concept of a new innovation center to test and implement payment reforms to affect delivery system change. CMS' current research and demonstration structure is not designed to achieve the kind of changes that are needed. We do, however, question the need to focus on "patients with multiple chronic conditions." While we agree that such patients have much to gain from delivery system reform, it is also desirable to focus on patients before they develop multiple chronic conditions.

Our experience evaluating managed care organizations and patient-centered medical homes leads us to understand that the following are key ingredients to improving care and reducing costs:

- A broad population-based approach that allows providers to target services for that population in a manner most likely to produce positive results
- Supplying providers with timely data that they can use for predictive modeling, targeting and taking action
- Understanding that addressing psycho-social needs may be important to being able to address health needs.

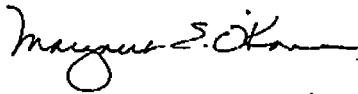
Accomplishing the above requires payers and providers to assume accountability for the health of a population and to work collaboratively to address the needs of that population. This is a shift from assuming accountability as a payer that simply contracts with providers. We hope that a new Center can adopt the new perspective and facilitate the needed approach.

### **Pay for Chronic Care Management.**

While NCQA fully supports the need for better chronic care management, we question the need to pay Medicare Advantage (MA) plans more for such services. Chronic care management is a core part of what an accountable care organization like MA plans should be providing. Also, while we favor tying a portion of MA plans' payments to their performance, we question the notion of paying them extra for "having a medical home." Medical homes should reside in a medical practice not at the health plan level so that practices are functioning as medical homes for all of their patients, not just those associated with one payer. Perhaps plans could be rewarded for providing incentives to their providers to create qualified medical homes along the same lines as the Medicare Medical Home Demonstration Project.

Thank you, again, for the opportunity to review and comment on the Committee's policy options for delivery system reform. We appreciate the open process that the Committee and its staff have adopted and look forward to working with you as this important effort to reform our health care system.

Sincerely,

A handwritten signature in black ink, appearing to read "Margaret E. O'Kane". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

Margaret E. O'Kane  
President