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Testimony
of the
American Hospital Association
before the
Committee on Finance
of the
United States Senate

"Improving Quality in Medicare: The Role of Value Based Purchasing"
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Good morning, Mr. Chairman. I'm Leo Brideau, president and chief executive officer of Columbia St. Mary's in Milwaukee, Wisconsin. On behalf of the American Hospital Association's (AHA) 4,800 hospital, health system and other health care organization members, and our 33,000 individual members, we appreciate the opportunity to express our views on legislation that can enable Medicare to better reward excellent quality.

Columbia St. Mary's is an organization of four hospitals, 26 clinics, and a college of nursing. We have all joined together to serve southeastern Wisconsin – with more than 155 years of service to individuals and families in these communities. Over the years we have earned a reputation for providing excellent state-of-the art medical care in a family-centered, healing environment.

Columbia St. Mary's is deeply involved in quality improvement activities both locally and nationally. Locally, with other Wisconsin hospital, physician and payer groups; and nationally, through our affiliation with Ascension Health, which is one of a few prominent organizations working closely with the Institute for Healthcare Improvement, we are working to improve the quality of care delivered to our patients.

In addition, I've had the pleasure of chairing a special committee of the AHA's Board of Trustees exploring options for future forms of payment for hospitals, physicians and other health care providers. The committee concluded that the current payment system must more fully promote quality initiatives, including pay for performance.

America's hospitals support the notion that payment incentives should be among a cadre of efforts to support and encourage improvement in health care quality.

A well-crafted system to reward excellent performance would be an important stimulant to the work that hospitals and health care professionals already are doing to improve care. In 2003, the AHA supported a provision of the Medicare Modernization Act (MMA) that made part of the hospital inpatient update contingent upon the reporting of 10 quality measures. At that time, more than 2,000 hospitals were already reporting this information. Therefore, hospitals are already reporting quality data as part of the Medicare program, and we believe it is time to move to the next step and tie some portion of payments to the performance of these measures.

We congratulate Senators Grassley and Baucus for their vision and leadership in creating a specific legislative proposal from the concept of rewarding excellence in care.

The Hospital Quality Alliance

We would like to outline the steps that the hospital field has already taken to address quality measurement and reporting. Mr. Chairman, America's hospitals are diverse … some large and urban, some small and rural, many in between. But each and every one of them shares a mission that can be summed up in two words: Patients First.

Part of putting patients first is helping them get the information they need to make decisions about their care. That is why the AHA helped lead the way toward the creation of a single national database of credible hospital quality information for patients. This effort – the Hospital Quality Alliance (HQA) – is a public-private collaboration to improve care by measuring and publicly reporting on that care.

In addition to the AHA, this collaboration includes the Centers for Medicare & Medicaid Services (CMS); Agency for Healthcare Research and Quality (AHRQ); National Quality Forum (NQF); AARP; Association of American Medical Colleges; Federation of American Hospitals; Joint Commission on Accreditation of Healthcare Organizations; American Medical Association; American Nurses Association; National Association of Children's Hospitals and Related Institutions; Consumer-Purchaser Disclosure Project, representing 52 leading employee, consumer and labor organizations; and AFL-CIO. The goal is to collect and report data on standardized and easy-to-understand hospital quality measures.

The HQA grew out of increasing requests to hospitals from insurers, businesses, accreditors, and government seeking reports on different measures of quality. While all of these parties shared the same goal – to provide information about hospital quality to the public – the burden, complexity and cost of complying with all of these requests was becoming overwhelming for hospitals. Confusion among consumers also was growing as they faced a potential avalanche of disparate information about hospital quality.

As a group, the HQA has committed to several things. Among them: using a common set of priorities to focus on national public reporting of hospital quality measures and patients' perceptions of care; working with NQF-endorsed measures where possible; and setting priorities that correspond to the six aims identified in the Institute of Medicine's

Crossing the Quality Chasm report. Working together, we are creating a more reliable, valuable, and broadly used set of information on hospital quality than any one of the organizations could create on its own.

The centerpiece of the collaboration is *Hospital Compare*, a new Web site developed to share with consumers information about the quality of care delivered in the nation's hospitals. Included on the Department of Health and Human Services' Web site, it debuted on April 1, 2005 at www.hospitalcompare.hhs.gov, and provides patients and their families a new tool that can help them make important health care decisions. In addition to measures of quality, the site provides patients with key questions to help them begin conversations about their care with physicians and other caregivers.

Seventeen measures currently are reported on *Hospital Compare* (see attached chart). The measures reflect recommended treatments for three conditions: heart attack, heart failure and pneumonia. These three were chosen because they are among the most serious and common medical conditions, and are measures that hospitals can collect in a consistent manner to submit for public reporting. The quality measures currently on *Hospital Compare* as well as those that will be added either have or will have gone through extensive testing for validity and reliability. They will be consistent with the best available scientific information and will be modified and updated as new scientific discovery dictates.

The hospital quality measures also are endorsed by NQF, a national standard-setting body, which means they have been deemed useful by representatives of consumers, purchasers, health care providers, and the research and quality improvement communities.

A Commitment to More – and More Useful – Public Information

The HQA is committed to expanding *Hospital Compare* to include more information on clinical quality, as well as information based on patients' perceptions of the care they receive. Patient information will be gathered through the HCAHPS survey, which is now in the federal approval process. HQA's goal is to ensure that hospitals use the survey to gather information on patient perception of care and share their data on the *Hospital Compare* Web site.

The HQA strongly believes that the public wants and deserves information on those aspects of quality that are best captured by asking patients for their thoughts. Did the doctor or nurse speak in ways you could understand? Did you get all the information you needed? Was the call button answered in a timely fashion? Was what you should be doing after leaving the hospital explained clearly to you? This is specifically the job for which HCAHPS was created.

Like the clinical quality measures that are already a part of the HQA, the HCAHPS tool, which is being developed by researchers working with AHRQ and CMS, has been developed, tested, refined, reviewed, and agreed to via the NQF consensus process. We

are eager to implement this survey and augment the data currently available on *Hospital Compare* with information that promises to be easier for consumers to understand and incorporate into their decision-making.

In addition to featuring data on patients' perceptions of care, the HQA plans to add information on whether hospitals have taken steps that have been proved effective in preventing serious and common complications of major surgery. We already are incorporating measures of preventing surgical wound infection, but by 2007 will augment that with information on the prevention of serious blood clots, peri-operative heart attack, and post-operative pneumonia.

Building on the HQA

The HQA is a very effective public-private partnership that is not only accomplishing its goal of making credible information available to the public, but also is reducing the measurement "babble" that had been generated by a large variety of separate organizations asking hospitals to produce quality information. All of these disparate data requests can impede rather than support quality improvement. The HQA has brought focus to hospitals' improvement efforts.

Significant resources already have been invested in the HQA effort and the *Hospital Compare* Web site by all of the participants. Nearly 4,200 hospitals – more than 99 percent of all eligible Medicare Prospective Payment System hospitals and nearly 400 Critical Access Hospitals – have committed to this process and have led the way by sharing data with their communities and the public. This is a solid foundation on which we must continue to build. And it should be the foundation for any pay-for-performance program included in legislation. To base the pay-for-performance initiative for hospitals on the work of a group other than the HQA would be a duplication of effort, and a loss of significant knowledge and expertise.

While the HQA is off to a solid and successful start, the group is already focused on improvements. One of the ways we need to build on the HQA is by allowing more hospitals to be able to participate. The HQA has determined that the current measures do not apply well when assessing care provided at certain types of hospitals. For example, they cannot effectively assess care in children's hospitals, psychiatric hospitals, rehabilitation hospitals, and hospitals that only treat patients with diagnoses other than heart attack, heart failure and pneumonia.

In addition, the current measures are not particularly effective for assessing care in hospitals with few heart attack, heart failure or pneumonia patients. This is particularly the case for small, rural hospitals. To remedy this, the HQA partners have brought together researchers with expertise in rural health care and quality measurement to help identify a set of rurally relevant measures of care.

However, the limited number of patients in small hospitals means that their performance rates can be volatile. In designing a system that rewards excellence, this type of volatility can lead to inappropriate conclusions about the quality of care at these hospitals, and affect whether they deserve a reward under an incentive program. At the same time, omitting small hospitals from the program may imply that they do not provide care quality that is comparable to that of larger organizations. The implications of this volatility in their data must be carefully considered so that hospitals with small sample sizes can participate and receive appropriate recognition for the excellence they achieve.

The HQA partners are working to determine what measures can accurately assess care for a wide variety of hospitals. It is critical that the group choosing these measures consider how to enable hospitals serving different types of patients to participate, as well as how to allow hospitals with small sample sizes to participate.

The Legislation

Again, we congratulate Senators Grassley and Baucus for introducing legislation that could impact Medicare payment through pay for performance, a concept we support. We believe this bill represents a good first step in moving our payment system forward to embrace the concept of pay for performance.

We would like to make several suggestions for improvement in the legislation. We urge you to amend the hospital-related provisions in the legislation that could create a parallel and duplicative quality measurement system, and to specify that the HQA measures and process are to be used. While quality measurement systems are not in place today for many of the other sectors of health care addressed in the bill, hospital quality measurement is well underway.

We also are concerned that the legislation seeks to tie payments to issues, such as cost-effectiveness, that could change incentives. We believe that pay-for-performance should focus solely on quality improvement. There is no common definition of the cost-effectiveness of care for hospitals. Cost-effective over what period of time? The course of a hospitalization … or a stated period? Also, cost effective for whom? The hospital … the patient … the government … other payers? Each answer would lead to different designs in cost-effectiveness measures and very different conclusions about whether care was cost-effective or not.

Measuring and rewarding performance based on a particular definition of “cost effective” also would have dramatic consequences for patients. Just a few years ago, for example, health maintenance organizations developed criteria for cost-effective care that their doctors and other providers were told to follow. But the ensuing headlines of denials of tests and treatments, and the accompanying public outcry, led to considerable changes.

Much more work needs to be done to define what should be encouraged in terms of cost-effective care before it is incorporated into legislation that could dramatically affect the care patients receive.

While quality reporting under the bill is voluntary, the legislation provides that hospitals that do not report quality indicators would be penalized with a 2-percentage point reduction in their annual market basket increase. This penalty is too great. A reduction of market basket minus 0.4 percentage points was included in the MMA for hospitals choosing not to report quality measures. It was sufficient to encourage virtually every eligible hospital to participate (more than 99 percent of eligible hospitals are reporting quality indicators based on this incentive). With such an outstanding response rate, we see no reason to increase the amount. The sizeable penalty proposed in the current bill is likely to hit those hospitals most strapped for the resources – financial and human – that are needed to collect data and report quality measures.

Further, to finance the payment rewards, the legislation would ultimately reduce all hospital Medicare inpatient payments by 2 percentage points from their standardized amount. This amount is too large for the first widespread Medicare experiment in rewarding quality excellence. We believe pay-for-performance is important and should be implemented, but we support a smaller pool of funds from which to test the concept. In addition, we would like to explore with the committee other sources of funding for this initiative.

Conclusion

Mr. Chairman, the mission of every hospital in every community in America is to provide the best care possible to people in need. To achieve that mission, hospital leaders, trustees, physicians, nurses and others in the hospital family constantly strive not just to keep up with the demands of delivering health care in their communities, but also to improve the way they deliver that care.

We believe that pay-for-performance initiatives can greatly facilitate their efforts. We also believe that an effective pay-for-performance program that truly improves care must be focused on care measurements, must encourage adherence to the best available scientific information, and must have as its foundation the successful collaboration we have achieved with the Hospital Quality Alliance.

We look forward to working with this committee and staff to forge ahead toward our shared goal of improving the quality of care for all Americans.