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Written Testimony on Value Based Purchasing Submitted to the Senate Finance Committee on Behalf of the Association of American Medical Colleges

Good afternoon, Chairman Baucus, Ranking Member Grassley, and other members of the Committee. My name is Gary Gottlieb, M.D., and I am President of the Brigham and Women's Hospital in Boston, Massachusetts. I am pleased to be here on behalf of the Association of American Medical Colleges (AAMC) and appreciate this opportunity to provide comments on the Value Based Purchasing (VBP) plan submitted by CMS.

The AAMC represents all 129 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and 96 academic and scientific societies representing 109,000 faculty members. The Association is a founding member of the Hospital Quality Alliance and a member of the National Quality Forum and Quality Alliance Steering Committee.

While the number of "pay for performance" or "value based" purchasing programs has increased over the years, the concept is still relatively new and its merits are still being explored through research and being debated in the literature. As a result, we believe that measured, careful planning and data collection will be essential for development of this capability, and are pleased to offer the following comments for your consideration. Because other colleagues on the panel will share many of the principles the provider community believes should apply to VBP, I will focus first on those issues that are unique to teaching hospitals. Thereafter, I will discuss our answers to the Committee's specific questions and our general views on the core components of a value-based purchasing plan.

Teaching hospitals are unique and vital to health care delivery and scientific discovery
The nation's teaching hospitals are committed to providing high quality care and sharing our experience and knowledge throughout the provider community. My own hospital, Brigham and Women's, is a 747-bed teaching affiliate of Harvard Medical School located in the heart of Boston dedicated to serving the needs of the community. It is committed to providing the highest quality health care to patients and their families, to expanding the boundaries of medicine through research, and to educating the next generation of health care professionals. We believe our efforts (and indeed, those of all teaching hospitals) will improve care for all Americans because of the close link between our unique clinical, education, and research missions.

Major teaching hospitals disproportionately treat complex and severely ill patients who often present with multiple co-morbidities and serious, or rare, complications of routine medical conditions. As major referral centers, we are often the recipients of complex and high risk patients who are transferred from non-teaching hospitals. In addition to caring for unique patients, we also provide unique services not found at other hospitals including transplantation, trauma and burn care, participation in clinical trials, and other services. While relatively few individuals may require this level of care at any given time, all Americans want these services

available should the need arise. Teaching hospitals often serve as the safety net for the community by caring for a disproportionate share of the poor and uninsured. We embrace our responsibility to ensure that the care we provide to all individuals is of the highest quality, reflecting the latest scientific evidence and technological advances.

Teaching hospitals, by definition, train future physicians and other health care professionals and must provide environments where quality care is practiced and lifelong learning skills are established. Moreover, because of our commitment to translational and clinical research, and as sites that develop evidence to support quality measures, we regularly analyze all aspects of care delivery to help improve outcomes for patients.

Individual components of VBP pose unique challenges for our institutions. For example, a long term, uniform approach to Hospital Acquired Conditions may be problematic and lead to unintended consequences. The CMS has recognized that the acuity and complexity of our patient population means that some complications and infections are not preventable. Nevertheless, payment may be withheld if these conditions were not identifiable on admission.

The existing program is based upon Present on Admission (POA) coding that cannot be quickly or perfectly implemented in many instances within the teaching hospital environment. Because teaching hospitals provide many emergency and standby services such as burn and trauma care, POA coding may be neglected because it sacrifices timely and appropriate—and often life-saving—care. Many patients admitted to our institutions are transferred from other facilities unable to provide a higher level of care and documentation from the original provider may be insufficient. Any plans for incorporating measures of hospital-acquired conditions into the VBP program need to take these issues into consideration before implementation.

Measurement design and applicability to teaching hospital patients

The measures that are currently in use have been developed primarily to measure the treatment of patients with one major problem with few complications. Because our patients are often more complex, with many serious co-morbidities, appropriate care plans can potentially run counter to the expectations established by these applied performance measures. For instance, desired outcomes for diabetic patients may be appropriately adjusted for frail, elderly patients whose condition is secondary to cancer-related steroid treatment. Patients with congestive heart failure secondary to chemotherapy or radiation may also require alternate process or outcome measures from those whose condition is due to longstanding hypertension or other disease. It is difficult for the acuity of our patients to be identified in the current performance measurement system, particularly if measures are only based upon administrative claims data. The severity and complexity of our patient population cannot be completely explained by existing coding systems and their use in VBP may have serious, unintended consequences.

We would respectfully suggest that more work needs to be done to identify a more effective risk adjustment model. According to CMS' own reports, even the most robust severity adjustment systems explain less than half of the differences in cost of care across Medicare discharges—that is, no current or proposed administrative coding system can fully describe how patients are different from one another even when they are reported to have the same principle diagnoses.[1]

[1] Centers for Medicare and Medicaid Services. CMS-1533-P. Proposed rule 2007-12-13.

Given the limitations of current approaches to measurement, perhaps an emphasis on rewarding proven processes that have been shown to improve efficiency, safety and reliability of care can spur achievable improvements in patient outcomes. In our own experience at Brigham and Women's Hospital and across our parent Partners HealthCare System, we have linked pay for performance initiatives with all three of our local payors who account for 40% or more of our revenue. We have developed mutually accepted targets for penetration of technologies that have been shown to improve care. These include computerized physician order entry, electronic medical records and electronic prescribing by our physicians and electronic medication administration records for nursing and pharmacy. In these and other areas we have already begun to see these incentives affect processes and institutional and physician behaviors favorably.[2] [3]

Measuring the value of unique services for complex patients
We support the use of measures that apply to the broad hospital population; however, we also believe this approach does not inherently reflect the unique value that teaching hospitals add to the healthcare system. While our institutions perform well on many existing measures, there is little opportunity to demonstrate performance across the range of complex care our institutions deliver which cannot be found at other hospitals.

ESTABLISHING MEASURES

All measures used in a value based purchasing program must be endorsed by the National Quality Forum (NQF) and approved by the Hospital Quality Alliance (HQA). The NQF consensus development process allows for multi-stakeholder review and approval. The measures are assessed using a framework that includes scientific acceptability, importance, feasibility and others. The HQA then reviews a subset of the endorsed measures and adopts those that are actionable by the providers in improving care so that consumers in are able to better assess quality / performance at a given hospital. The current model has worked well thus far for the Hospital Compare program and should be adopted by any VBP program.

All measures must be field tested prior to implementation
We would recommend that all measures included in the VBP plan should be adequately field tested and evaluated in a broad variety of institutions prior to their inclusion. The testing must show any measure is properly specified for national data collection, has strong reliability and validity, and that the measure is functioning as intended. Proper field-testing should also be able to identify any unintended clinical consequences prior to national implementation.

All measures need to be actionable
The HQA approves a variety of process, outcome and patient centered care measures. While these measures are most relevant for public reporting, not all of the selected measures would be appropriate for a VBP program. Clinical process measures provide clear direction to hospitals in how to improve performance and can impact the level of performance within a relatively short period of time. However, outcome and patient-centered care measures are often difficult to

[2] Bates DW, Leape LL, Cullen DJ, et al. Effect of computerized physician order entry and a team intervention on prevention of serious medication errors. JAMA. 1998;280:1311-1316.
[3] Poon EG, Cina JL, Churchill W, et al. Medication dispensing errors and potential adverse drug events before and after implementing bar code technology in the pharmacy. *Ann Intern Med*. 2006;145:426-434.

measure accurately and hospitals may not be able to identify clear steps to take in order to improve performance. Putting hospitals at risk of losing their incentive payment based on measures without clear paths for improvement would not serve to improve value.

All measures should be reviewed annually

We believe it is essential that a system be in place to regularly evaluate performance measures for any changes to the underlying scientific evidence (often provided by investigators at teaching hospitals) and to monitor for unintended consequences. As an example, treatment of heart failure due to left ventricular systolic dysfunction (LVSD) for a long time required the use of an angiotensin coverting enzyme (ACE) inhibitor. However more recent scientific evidence has shown that the use of angiotensin receptor blockers (ARB) is more effective. Changing this measure required a significant amount of effort and required over a year's time to implement. During this time period, many academic medical centers had already adopted the use of ARBs and were being measured on an approach that was outmoded. In some cases, the most appropriate treatment for particular patient populations as determined by age, sex, race and other factors may change as new evidence becomes available.

Annual review would help ensure all measures used in the program are scientifically relevant and measuring what it was intended to measure. If new evidence suggests a measure is no longer scientifically appropriate or needs to be evaluated then the measure should be suspended until a thorough and timely review can occur. Similarly, if new evidence shows that a particular performance measure is promoting a practice that may put patients at risk it should also be suspended; in recent years, major studies related to intensive treatment of diabetes and hormone replacement therapy in women have rapidly changed medical practice. Processes need to be in place to conduct reviews and procedures must exist to modify the program if a measure needs to be altered mid-cycle.

INCENTIVES

Another special issue for teaching hospitals is the mechanics of VBP payment arrangements in light of special support meant to partially reimburse hospitals for their costs related to training health professionals or their other associated missions. We agree with CMS that the foundation for the incentive payment should be the base inpatient DRG payment and should not include any additional payments used to reimburse hospitals for the costs related to graduate medical education, care for the indigent or for outlier cases. GME and DSH payments have specific purposes that are distinct from routine care delivery and it would be inappropriate and bad policy to risk eroding the education of future physicians, care for the underserved, and treatment of complex patients.

Size of the incentive payment

We agree that the size of the incentive payment should be significant enough to motivate change. As demonstrated by the Premier Demonstration project and the current pay for reporting program, a small percentage of payment put at risk can result in a significant change in performance. For the initial implementation of the VBP program we recommend that no more than 1% of the base payment for the affected DRGs be used for funding.

Affected DRGs
As mentioned above, the incentive payment should be applied only to the affected DRGs for the clinical condition areas being measured. Using the specific DRGs would ensure that the incentive is being applied directly to those cases being measured.

Unallocated incentive payments
There is the possibility, after the incentive payments have been distributed, that all of the funding used for the incentive payments would not be paid out therefore leaving unallocated funds. We strongly recommend that the unallocated funds be re-distributed, within the same program year, back to hospitals to further assist them in their quality improvement efforts. How the funds are re-distributed will depend on how the VBP plan is ultimately structured.

IMPLEMENTATION

Timeline
In order to allow for both hospitals and CMS to appropriately prepare and understand how the VBP program will function, we recommend a phased-in approach to occur over several years. As a new and complicated program without a substantial evidence base, implementation should be incremental and rigorously evaluated.

Infrastructure
We believe the infrastructure needed for the pay for reporting program is significantly under resourced, lacks flexibility, and has had difficulty in successfully supporting the current RHQDAPU program. Before any VBP program is implemented, federal funds should be used to increase the capacity of hardware and software used in data submission, provide technical assistance, and modify the Hospital Compare website. Additionally, the infrastructure should allow for hospitals to resubmit their data should they discover an error after the close of the data submission period.

Validation process
The current validation process does not include current scientific standards for sampling and validation. The current sampling of five (5) charts per hospital is too small to determine validity and accuracy. The proposed random, targeted approach for validation and increasing sample size is a step in the right direction, however further research will help determine the most scientifically relevant and statistically sound approach.

Appeals process
We believe that improvements must be made to the current appeals process so that it is clearly defined, transparent and timely. Hospitals should have clear guidance on how to submit their appeals, and CMS should expedite its appeals decisions. Additionally, the timing of the appeals process should allow for hospitals' payments to remain at their expected levels while validation appeals are ongoing.

Cost/Burden
We are concerned with the potential proliferation of measures for the current pay for reporting program and then ultimately value based purchasing if legislated. Hospitals are contributing valuable resources in time and staff costs to collect and report the data necessary as well as implementing the necessary steps to improve performance. This may leave little room for

hospitals to continue their own quality improvement activities beyond the CMS required condition areas. Effort should be made to identify ways for hospitals to incorporate their own ongoing quality improvement activities, including research, into more relevant measures. This will reinforce the fact that quality improvement is beyond the required measures at any point in time.

PROGRAM EVALUATION

As one systematic review of pay for performance published in 2006 explained, "the empirical foundations of pay for performance in health care are rather weak."[4] We hope that further efforts by the Congress and the Administration will help to build on this weak foundation of evidence to better understand the impacts of VBP experimentation before major policy changes—and potentially unintended consequences—occur.

Monitor for intended and unintended consequences

Implementation of a VBP program would be a significant shift from the way hospitals are currently paid under the Medicare program. Such a program will present challenges both to hospitals and CMS to implement. Significant resources should be made available to conduct ongoing monitoring and evaluation of the program including an actuarial analysis. This is necessary to identify the impact of the program on quality of care, cost savings, continued weaknesses in the program's infrastructure, best practices and any unintended consequences. The evaluation should be conducted by a third party reporting to Congress and the public.

CONCLUSIONS

Creating a payment policy that rewards improved performance without jeopardizing quality care is a worthwhile and challenging goal; there remains "considerable need for progress on a research agenda for studying financial incentives in health care."[5] Congress has, since the inception of the prospective payment system, recognized the inability of administrative data to fully reflect the unique missions of teaching hospitals. We look forward to working with the Committee to ensure that any VBP system provides value to patients, payors, and providers while at the same time continues to "first, do no harm" to the nation's teaching hospitals and the patients and families they serve.

Thank you again for the opportunity to testify before the Committee on behalf of the AAMC.

[4] Rosenthal MB, Frank RG. What is the empirical basis for paying for quality in health care? Med Care Res Rev. 2006;63:135-157.

[5] Desai AA, Garber AM, Chertow GM. Rise of pay for performance: Implications for care of people with chronic kidney disease. *Clin J Am Soc Nephrol*. 2007;2:1087-1095.