FEDERATION OF AMERICAN HOSPITALS
TESTIMONY BEFORE THE
SENATE COMMITTEE ON FINANCE
ROUNDTABLE DISCUSSION OF VALUE-BASED PURCHASING FOR MEDICARE
March 6, 2008

On behalf of the Federation of American Hospitals (FAH), I am pleased to offer our views on value-based purchasing (VBP). FAH is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as rehabilitation, long term acute care, psychiatric and cancer hospitals.

The 2001 Institute of Medicine (IOM) report *Crossing the Quality Chasm* made an urgent call for fundamental change to close the quality gap that exists in the United States health care delivery system. It asserts that one of the primary reasons for quality concerns has been the unsystematic and highly fragmented approach to patient and population health. IOM's report led to increased and focused attention on the quality of health care in America and a general consensus that improvements need to be made. While there are a host of innovative ideas to improving quality, there is no consensus on what approaches hold the most promise for specific diseases or conditions. This discussion is a timely opportunity to explore the best possible pathway for the thorough, appropriate and accurate measurement and reporting of quality care, and whether to link payment to performance.

Question to Frame the Discussion (What are we trying to accomplish?)

- **Should the purpose of a hospital value-based purchasing program be to provide incentives for quality improvement, to partially base payments on the value of care provided, or both?**

A critical issue to be decided before proceeding with a detailed discussion of value-based purchasing is what is the overarching goal? Is the goal to improve quality of care to patients or is it to pay for value? Paying for value is more complex. The current pay-for-reporting system is focused on improving quality through the use of quality indicators. To move to a VBP system requires the development of measures that clearly link measurement to patient outcomes.

Our members believe that the primary goal of VBP should be to improve the quality of patient care. The process for developing a VBP system must be transparent, involve all stakeholders and ultimately result in improved quality. The most efficient way to drive the delivery of patient care toward greater quality is to evaluate a number of existing initiatives:

- The Federation is pleased to have been a part of the creation of an overall national infrastructure for quality measurement in response to the IOM report. The quickly emerging public-private national quality and performance measurement and reporting infrastructure includes the National Quality Forum (NQF), the Hospital Quality Alliance (HQA) the AQA, the Quality Alliance Steering Committee (QASC), the American Health Information Community (AHIC), the Agency for Healthcare Quality and Research (AHRQ), and the National Committee for Quality Assurance (NCQA).

The Federation is, and has been, a strong proponent of quality and performance measurement and reporting for many years. Arguably, the current pay-for-reporting system is a form of pay-for-performance. The federal government currently makes what is tantamount to incentive payments in the form of a full-market basket update for hospitals reporting on certain quality measures of patient care including process measures, outcomes and, soon, patient experience of care. Hospitals that fail to report experience a two percentage point reduction in their update. The current pay-for-reporting program demonstrates, quite clearly, that reporting alone has a significant effect on hospital quality performance. Since the inception of the quality reporting program, and even before payment was linked to the program, across-the-board improvement has been realized for the quality measures for which public reporting is required. There is every reason to believe that this will continue under the current structure.

The FAH supports moving to a payment system that links payment to performance; however, we urge Congress to proceed carefully. It is critical that measures used in a new system to pay for value must encourage and correlate with improved patient outcomes. Unfortunately, at the present time, our national quality infrastructure does not have sufficient methodologies for determining if patient outcomes are better because of process measures being employed as part of patient care routines. The most effective VBP system is one that proves the relationship between process measures driving patient care and ultimate patient outcomes. Such a system requires the alignment of payment and incentives across the care spectrum, including clinicians, nurses, and institutions.

The Federation recommends looking at quality improvement as a larger enterprise. The identification of appropriate measures, fine-tuning of the developed measures, measure implementation, and finally evaluation as to whether the measures are actually succeeding in improving care and efficiency are all part of the enterprise. The effort to get both the quality of care and payment "right" is being tested in a variety of settings, including the private and public sectors. Non-payment related initiatives such as mandatory reporting requirements and the broader use of information technology targeted at increasing quality are also appearing in numerous marketplaces.

<u>Quality Measures</u>

- **What process should be followed to develop, test, refine, endorse, adopt, and retire quality measures used in the Medicare VBP program?**
- **What types of measures should be employed (or phased-in) – process, structure, outcome, patient experience, efficiency, etc.?**

- **How do we ensure that hospital measures (and measurement processes) and physician measures are complementary?**

The FAH has been an integral member of the National Quality Forum (NQF) for many years. At present, FAH President Chip Kahn serves on the NQF board and is actively seeking to increase the capacity of the organization to prioritize, review and endorse quality measures.

The role of NQF should be to review measures developed by others. This ensures that measures are scientifically valid, that the methodology for collecting data has been considered, and that the measures have been tested. Numerators and denominators need to be very well defined, and the data source must be defined. Measures should clearly define which conditions might exclude a patient, and which patients should be included. Ill-defined measurement specifications have resulted in a wide variety of problems, including confusion by abstractors and the inability of electronic health record vendors to include measure reporting as part of their functionality.

Any measure used in a VBP system must first have a period of a minimum of one year of being collected and an additional year of public reporting before being rolled into a VBP system. It is not until there is widespread reporting and collection of data that problems with specific measures are really discovered. The measures then can be fine-tuned for continued use.

Not all measures approved by NQF are necessarily appropriate for hospital measurement. The HQA reviews available measures and makes recommendations to CMS for which measures are ready for inclusion in the hospital quality reporting system. We strongly recommend the same system under a VBP system.

The addition of measures to a system over time must be focused on those that will do the most to improve quality. The NQF is currently undertaking a project with all of its partners to develop a set of national priorities for quality measurement. This will help to focus the attention and work of measure developers, clinicians, hospitals and other providers. We recognize that there are limited resources and that we cannot just keep adding measures without focusing on which measures and conditions will have the greatest impact on quality of patient care.

It may also be appropriate to retire measures over time. Currently, the HQA and NQF are thinking through how to handle measures when the average achievement rate is in the top two deciles for the majority of hospitals. If we retire measures, how do we ensure that those processes are being used in patient care? Should measures still be reported, but not used for VBP or should measures be retired completely and energies focused on new priorities? HQA and NQF hope to answer these questions over the next several months.

A variety of measure types should be collected and reported. In a VBP system, each type of measure needs to be weighted to achieve the highest quality outcomes. Process measures, with which hospitals have the most experience, should receive a higher weight

than outcomes or patient experience measures in a VBP program because they are the building blocks for long-term improvement. Patient experience measures are important, but they are indicators only, not quality measures linked to specific clinical outcomes. Therefore, the Federation would recommend weighting patient experience measures lower than process or outcome measures.

The FAH urges alignment between hospital measures and measurement process and physician measures and measurement processes. NQF is looking at this very topic. There are several measure sets that are very similar between hospitals and physicians, but the data sources are different. One source will be claims data and the other is data collected from abstracting patient charts. Coding of various aspects of patients charts may be different in different settings. The process to solve these problems is underway, but is not complete.

Health information technology and the use of electronic health records may be helpful in the future, but we first need to ensure that physicians and hospitals are collecting the same information in the same format. Solving this dilemma becomes critical as we develop measures to assess episodes of care.

Performance Standards

- **How should the program balance rewards for achievement of (1) minimum thresholds of performance; (2) "high performance"; and (3) improvement?**
- **On what basis should thresholds and benchmarks be set and changed?**
- **Should the program provide incentives for each measure/patient condition or base payments on a combined score – and how, if at all, should that differ from what is publicly reported?**

Any change in payment attributable to a VBP program must be incremental. There is simply insufficient data and experience in modeling VBP to know what the long term impact will be. The Federation recommends that goals be realistic and should recognize and adapt to the fact that hospitals may have a unique set of services and circumstances. Ultimately, Congress should be interested in the steady quality improvements of each and every hospital. One way to accomplish this is to ensure that sufficient resources are available to stimulate hospitals at the lower end of a measurement scale up the scale. Therefore, the overall incentive payment should ensure that sufficient funds be targeted at the lower performing hospitals.

At the same time, top performers should be rewarded in terms of receiving their full payments from any withholding pool. The scale, including thresholds and benchmarks, for determining how payments are made to hospitals could be adjusted over time with the scale or curve at the beginning of the program emphasizing improvement and then gradually moving to a scale that is a more traditional bell curve with small tails so that the majority of hospitals would be in the performance percentiles that would ensure at least full payment.

No matter what scale is chosen, it is imperative that both improvement and attainment be rewarded and that, across all hospitals, all of the funds be returned in any given year rather than withheld in a pool for future performance, or returned to the trust fund.

The CMS report on VBP recommended publishing the thresholds and benchmarks prior to the year in which hospitals would be measured. The FAH agrees that knowing thresholds and benchmarks a year in advance is very helpful. Benchmarks for one year should be based on performance for the previous year. That way benchmarks would be based on actual data and hospitals would know what they have to do to achieve the goal.

The FAH recommends that benchmarks be set at a level realistically achievable for the majority of hospitals. The Federation also recommends that any VBP program be phased-in over a four year period of time. During the first several years of the phase-in period, we would recommend that the benchmarks be stable until all hospitals are familiar with the processes and can better assess their improvement.

A VBP program should be based on composite scores by condition. The individual measures regarding a given condition should roll up to one composite score for that condition. In other words, using today's measures there would be one score for heart failure, one for acute myocardial infarction, one for pneumonia, and one for the surgical infection prevention measures. The FAH recommends that composite measure reporting also be employed on Hospital Compare. The initial screen should display composite measures of quality. If a patient wishes to delve deeper into the data, they should be permitted to click on a condition and see the individual measures that were combined to achieve the overall score.

Structure of Incentives

- **Should incentives be applied to services related to certain measures, all DRGs, or base payments?**
- **What degree of incentives is necessary to promote adherence to quality measures?**
- **Should all participating hospitals have their payments affected, or should the incentives be "curved" so that a certain portion of hospitals do not receive a financial consequence?**

The structure of the incentive package is extremely important. Any withholding of funds to create incentives should be related only to the DRGs affected by the specific quality measures, and should not apply across the board to all DRGs.

Public reporting alone, as revealed by the work of Judith Hibbard and others, results in significant improvement in quality. The Premier demonstration project, for its part, clearly shows that a small incentive payment is more than a sufficient motivator in terms of accelerating improvement. Therefore, the percentage of the payment for the DRG should be small. Any incentive funds left after they have been disbursed should be returned to all hospitals.

Implementation

- **What kinds of hospitals should not be included?**
- **What phase-in/data collection period will be necessary to establish performance benchmarks and allow hospitals to adapt their systems to participate?**
- **What resources do CMS and hospitals need to implement this program, including those needed to collect and analyze data in a timely manner?**
- **What kind of auditing/verification process should be implemented and what appeals rights should participating hospitals have to challenge results?**
- **How should the program be monitored on an ongoing basis?**

The program should apply to all hospitals, including critical access hospitals, and measures should be reported for all services, including pediatric services. Consequently, the Federation requests that any legislation authorizing VBP explicitly state that, even though the Medicare program does not pay for children's services, the ability to report these measures on Hospital Compare is important for providing a comprehensive view of the overall quality of a hospital, and those measures should be included. The Federal data warehouse must be able to accept data on pediatric measures, and the Hospital Compare web site must be able to post pediatric quality data.

A new program, particularly one that would involve such significant change for hospitals, requires a phase-in period. The Federation would recommend that a new VBP program be phased in as the pay-for-reporting program is phased out over a four year period of time. For example, year one of the program would be 25% VBP and 75% pay for reporting. Year two would be 50% VBP and 50% pay for reporting until VBP was completely phased in during year four.

Some hospitals may have too few cases on certain measures to be included in a VBP program. Their data may not be statistically stable or sufficient and may not be truly indicative of their real performance. Consequently, a minimum annual number of patient cases should be established for participation in the VBP program. Initially, the minimum number should be 25, the same threshold currently used for deciding the manner in which a hospital's performance data will be displayed on Hospital Compare. Those hospitals with fewer than 25 cases still should have the opportunity to have their data publicly reported; however, they should not have their payments reduced to fund the VBP program. Finally, hospitals should have the opportunity to opt out of measures that are not applicable to their institutions and receive from CMS written confirmation of the opt-out decisions for the measurement period.

Attention needs to be paid to the infrastructure and validation processes. The FAH strongly supports a proposal to allow hospitals and their vendors to review and resubmit data, if necessary. At times, the communication between the vendors and the QIOs has not been complete, leading to programming errors. When these errors are found post-submission and are a result of incomplete or mistaken information on the part of the QIOs, the vendors and hospitals should have the ability to correct the errors and to resubmit data.

Going forward, a new VBP program should encourage coordination among vendors, CMS, and the Joint Commission, including the need for clear definitions and alignment during a transition. Hospitals and vendors will need extremely detailed guidance on what will be included in each reporting period. Improving the ability of vendors to help their hospital clients to the fullest extent is essential.

The FAH supports revamping the current validation strategy that samples only a very small number of cases from all hospitals and assesses the accuracy of all submitted data elements, even those not directly related to the delivery of the intended care. FAH would support strengthening the data validation program through a combination of random and targeted audits with a larger case sample size. We recommend that the audits be limited to review of data submitted in the year in which the audit is conducted and that recoupment of funds for incentive performance in previous years not be permitted.

The Federation is a charter member of the HQA, a multi-stakeholder, public-private collaborative which reviews and recommends quality and performance metrics for use by CMS and others. The HQA has proven to be a workable model of the public and private sector collaboration that can contribute significantly to improving the quality of patient care in the hospital and creating better value for the health care dollar. The HQA is only one key entity of a quickly emerging public-private national quality and performance measurement and reporting infrastructure. Other organizations include the National Quality Forum (NQF), the AQA, the Pharmacy Quality Alliance, the Quality Alliance Steering Committee (QASC), the American Health Information Community (AHIC), the Agency for Healthcare Research and Quality (AHRQ), and the National Committee for Quality Assurance (NCQA).

Working through public-private partnerships is a new, appropriate and effective way of improving healthcare quality. The federal government simply financially cannot afford to run a complex quality measurement system – nor is it up to the task of maintaining such a system without additional funds. On an operational level, the system will work better if all parties have buy-in from the early stages. The federal government is critical in providing the health information technology infrastructure; however, adding measures to a reporting system does carry a cost both to hospitals and to the government. There is a cost to the government to retool software for data collection and processing and for updates to Hospital Compare, the website for public reporting. There also is a cost to the collection process at the hospital level.

This cost could be minimized at the federal level if systems were appropriately designed to accommodate measure expansion. Unfortunately, at the present time, the system is not sufficiently funded and significant redesign is needed and appears to be underway. The current hospital quality system must move to a more stable platform where retooling is not necessary when new measures or types of measures are added.

The Department of Health and Human Services (HHS), and specifically CMS, needs very targeted funds to expand the data warehouse, as well as the mechanism for receiving data

for physicians, processing data and sending reports back to hospitals. Specific funds need to be authorized for expansion and revamping of Hospital Compare so that patients, their families and researchers are able to easily and quickly find the information they need. HHS should be asked to be flexible in its thinking about the various compare websites. Not every site needs to look or function the same and, rather, must be tailored to the audience using them.

Indications are that the current data storehouse and processing mechanism at the existing funding levels will be incapable of managing even the modest expansion of measures anticipated in the next several years, particularly given the addition of outpatient measures this year.

Furthermore, the current website is not easy to navigate. A new enhanced website needs to be more consumer friendly, and should provide for easy comparison of hospitals across all types of patients. The site must be robust and highly useable for consumers, physicians, providers, employers, third-party payers, and researchers. We commend CMS for recognizing this need in their report to Congress, but the website, for the current reporting program, must receive a major upgrade now.

Finally, to support the overall quality infrastructure and to ensure a robust supply of measures highly focused on a clear set of priorities, the Federation urges the Committee to consider legislation that would recognize the role of the National Quality Forum as the national priority and goal-setting organization for quality and performance measures. As such, the role of the NQF as the sole evaluator and endorser of measures for the purpose of public reporting programs should be supported through federal funds. NQF is critical to overseeing the harmonization and maintenance of endorsed measures.

The Federation seeks recognition of the Hospital Quality Alliance role as the sole stakeholder group that advices CMS on measure reporting for hospitals.

During the phase-in period, MedPAC should carefully review hospital data and publicly report any adverse impacts of the movement to VBP. A comprehensive review of the new payment system should be conducted after year four.

Conclusion

The Federation appreciates the opportunity to comment on the questions posed by the Committee and to respond to any additional questions during the roundtable discussion.