Statement
of
American College of Surgeons

to

Senate Finance Committee

by

Frank G. Opelka, MD, FACS

RE: Hospital Value-Based Purchasing Program

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Chairman Baucus, Ranking Member Grassley, and distinguished committee members, thank you for the opportunity to testify today on behalf of the 74,000 Fellows of the American College of Surgeons. My name is Frank Opelka. I practice colorectal surgery in New Orleans, and serve as Vice Chancellor for Clinical Affairs at Louisiana State University.

We are grateful to you for holding this roundtable on the hospital value-based purchasing program. The American College of Surgeons (ACS) believes that questions surrounding hospital value-based purchasing must be framed within the overall goals for our nation's health and healthcare. It is our goal to relieve the pain, suffering and burden of disease for patients and for society with improved quality, efficiency and cost-effective care. The term "value" implies that high quality, though extremely important, is only one component of the equation. Payments to hospitals should be partially based on components that bring value to patients and to the larger healthcare system.

Purchasing decisions should be based on metrics that promote the six quality aims laid out by the Institute of Medicine. During the early stages of value-based purchasing, it will be difficult to focus on all components simultaneously. Instead, the purchasing program may address safety or effectiveness in some instances and promote equity in care or efficiencies of care in others. Our ability to target all of the IOM's six aims is greatly dependent on the availability of research and metrics that allow for valid measurement.

The complex variables involved in care that are not captured in current measurement tools remind us that we are still in the earlier stages of development in many of these areas and suggest that we should be cautious before forming the complete foundation for value-based purchasing. Additionally, there are few data indicating that the measures currently available are actually moving us toward our goals. Current measure sets still require more field-testing to determine that we are, in fact, improving the quality of care.

Process for developing, testing, refining, endorsing, adopting, and retiring quality measures used in the Medicare VBP program

If we borrow from the directions promoted by the Quality Alliance Steering Committee and the National Quality Forum (NQF), the first step is to perform an environmental scan and assess the population-based needs for healthcare improvement. The NQF is making a great start in its National Priorities Partnership Initiative (NPPI), which is charged with defining opportunities for improvement by outlining areas where measures are needed.

The ACS agrees with the many organizations, including the NQF, that have focused on the vital importance of comprehensive, continuous and longitudinal care for patients suffering from chronic diseases. However, we have concerns that the NPPI is not inclusive enough in addressing the numerous aspects of care, such as defining quality and efficiency in acute care settings. As these initiatives move out of their early development stages, we look forward to improved collaboration with all facets of the healthcare system.

Performance measure development continues to experience the tension between what may be adequate for improvement versus what is perfect. The ACS believes we cannot wait for perfection and that current processes for measure development within the Physician Consortium for Performance Improvement (PCPI) and endorsement by the NQF are onerous and too slow. The end product has been met with mixed reviews because some measures are very basic and others are true representatives of opportunities for enhanced care. We support the PCPI and the NQF as the sources for development and endorsement, but their processes must mature to meet the needs of a true value-based purchasing system. These yet-to-be developed processes include:

1. Uniform adoption by public and private payers as a means of promoting rapid field testing;
2. Analytics for the field tests to examine the outcome versus the expected goal;
3. Refinement through harmonization, and composite measurement;
4. Retirement processes for performance measures that demonstrate no quality impact or that have moved from representing a gap or variance in care to becoming a common practice.

What types of measures should be employed (or phased-in) – process, structure, outcome, patient experience, efficiency, etc.?

All measure types have value and focus of different aspects on patient care or different approaches to improvement. Composite structure measures such as the NCQA measures within the physician recognition awards are valuable. Individual process measures have some value if they are direct drivers of outcomes. Composite process measures may also improve care by assuring that more of the basic care elements are built into the standards of delivery. Providers might need multiple types of measures, including process, outcome and patient experience, to diagnose and solve problems within their practice. Patients, however, are less interested in structure or process measures and are more focused on the outcome measures because the information is an easily understandable and valued indicator of quality.

We currently lack measures that are longitudinal in nature. For example, how well did the cancer care provided in year one provide the best quality of life and survival in year five? Perhaps the first year of care was excessively expensive in institution A versus institution B for the cancer care of similar patients. However, when analyzed in year five, the overall cost for institution A may be less than institution B and the patients may experience increased survival and a better quality of life. We are unable to effectively measure long-term disease management with our current set of performance measures, which could mean we are rewarding the wrong providers.

Efficiency measures are critical if we are to address the issue of per capita cost. Beyond the measurement of efficiency is the need for a shared network for decision making, processes and overall systems of care. The complex nature of these measures and the tension caused by the disruption of the care and payment silos will prove a barrier to success. A multi-stakeholder solution will prove to be an important component.

Finally, patient-shared decision making is a critical missing link. The first step is evaluating patient experience with care. The American College of Surgeons and the Surgical Quality Alliance are actively working to enhance the scope of patient experience surveys using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) models by creating a surgical CAHPS survey. Beyond the patient experience, we believe improving the informed consent process within the challenges of health literacy is an important step. Dynamic informed consents that provide expected outcomes information and an overview of comparative effectiveness would improve patients' understanding of the proposed care plan. A standardized approach would assure more patients have an opportunity to enhance their informed decisions.

Ensuring that hospital measures and physician measures are complementary

The ACS feels this is an area for improvement. We have a compensation system that divides these two provider groups, but to bring alignment, the goal must be focused on opportunities to improve patient care. Once these opportunities are defined, the separate measures need to be brought together into a harmonized measure set that is inclusive of all providers caring for the patient. By harmonizing this process, measures can be organized into composite measures such as "physician-ordered" measures versus "hospital-delivered" measures. This harmonization could greatly improve patient care and reduce the burden of data collection for providers. However, to be successful, appropriate incentives must reward all provider groups.

Performance Standards

How should the program balance rewards for achievement of (1) minimum thresholds of performance; (2) "high performance"; and (3) improvement?

A balanced approach is critical. With a shortage of providers in many areas, it is important that the payment system encourages improvement. The top ten percent of the healthcare system cannot provide care for the entire population, so "high performance" rewards should be kept minimal. If the goal is to improve quality for all patients, it is important to improve the quality of as many providers as possible.

On what basis should thresholds and benchmarks be set and changed?

Thresholds and benchmarks will move in an evolving healthcare system. Initial thresholds should be based on the best available data. Future thresholds and benchmarks should be based on data from previous periods. When thinking about national benchmarks, it is important to remember that some of the challenges may vary by geographic regions. In these instances, payments for improvement will be critical. In general, tracking performance should seek to move the thresholds and benchmarks with the final benchmark reflecting the ultimate objective. At that point, the measures will need an assessment for the sustainability of care in the absence of a measure. Once this sustainability is achieved, the measure may qualify for "retirement".

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?

Incentives per measure fit the current purchasing system within a resource-based relative value scale. Looking at the physician level, the ACS recognizes several of its members are highly specialized and limit operations to a specific organ where high level technical skill and clinical decision making are required. For example, liver transplant surgeons or trauma surgeons may have very focused practices and limited exposure to other areas. Other more broad disciplines may be better suited to a combined score. For example, composite measurement may be ideal for chronic care of 8-10 common chronic diseases where there are 25-30 measures that encompass the majority of care for a provider.

At the hospital level, composite score based on care bundles might be appropriate and easier to administer than payments for individual measures. In many cases, a composite score confined to one area of care (e.g. heart failure patients) will also be most useful for public reporting to consumers who have little understanding of the impact of individual measures.

<u>Structure of Incentives</u>

What degree of incentives is necessary to promote adherence to quality measures?

We do not think this is a question that has been adequately addressed. We should look to the current programs, such as the Physician Quality Reporting Initiative and the inclusion of performance measure requirements for hospitals to receive their full payment updates, for additional insights. It is clear that the incentive must cover the costs of implementing change at the very minimum. However, exact numbers and percentages need additional research and will likely vary among providers.

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 ACS feels that not all communities and their hospitals can afford the startup costs for system level improvements. Rural and safety net facilities may lack the expertise to develop the broad scope of work in all areas to meet the level of performance of more mature and

developed health care systems. This could further hamper the ability to recruit providers and to develop improvement programs in these systems. These facilities may require a longer time period for the transition from mere reporting to value-based purchasing. Their thresholds and benchmarks may be linked together and compared as a separate group. The overall financial impact of underperformance may require a lower level of risk.

Implementation

What kinds of hospitals should not be included?

If special considerations are given to rural, safety-net hospitals and other hospitals with a barrier to rapid improvement, all hospitals should be included.

What phase-in/data collection period will be necessary to establish performance benchmarks and allow hospitals to adapt their systems to participate?

ACS feels that tested measures which have gone through a period of reporting, initial analysis and public vetting for a value assessment are ready for full implementation. If reporting takes six months to a year for adequate data aggregation, and analysis and public vetting add an additional six months, that would suggest a measure or set of measures would have thresholds and benchmarks at the end of the year and be ready for use in a value-based purchasing system. We should note, however, that measures designed to target a relatively small patient population will need additional time to amass the needed volume for statistical accuracy in establishing thresholds.

What resources do CMS and hospitals need to implement this program, including those needed to collect and analyze data in a timely manner?

ACS has several large clinical registries and has an appreciation for the challenges of data aggregation. Many aspects of data aggregation are manual and involve chart extraction. It will be some time before electronic standards with true interoperability have pierced enough of the markets to allow for rapid information streams. Thus, standards for aggregation and audits are important aspects of the program. The ACS experience involves certifying the data aggregators to assure integrity across the system. CMS and the hospitals will need to establish these programs as well.

Furthermore, true alignment of all providers to assure the best outcomes will require new resources for developing programs that need to mature into integrated systems. Many small, rural, and safety-net hospitals will need more leadership teams to analyze and define areas for improvement and develop processes and systems that assure a high level of performance and support a patient focused experience. For these systems, start-up funding could be required.

What kind of auditing/verification process should be implemented and what appeals rights should participating hospitals have to challenge results?

As long as there are manual processes involved, value-based purchasing will require auditing. In much the same manner as the Joint Commission, effective audits would seem to

require an evolution. Initial audits should be focused on identifying opportunities for hospitals to receive support and remedies for inadequacies. Subsequent audits may involve securing the integrity of the program and could carry punitive elements.

Given that lack of field testing, hospitals may notice certain measures are ineffective, expensive and do not enhance the quality of care. During the initial life of a measure, providers should have the right to appeal based on established criteria for individual measures. Once a measure has survived its testing, hospital appeals will require a different set of criteria weighted more around the thresholds and benchmarks and individual circumstances. Perhaps a focus on the sample size will reveal unrecognized hurdles. In addition, in early phases of the program, data collection and submission changes will provide inaccurate data that hospitals should have the right to appeal.

How should the program be monitored on an ongoing basis?

Value-based purchasing is a large program with obvious complexity. Measures will require monitoring for their ability to contribute to value. As noted previously, measures require testing, updating, and retirement criteria. The PCPI, NCQA, and NQF are great organizations for assuring success in maintenance of the measure sets.

The priorities for health and healthcare will change over time. Population health scans will need to continue to assess the areas for necessary focus and improvement. Patient experience and needs will develop as these programs alter the health literacy profile of each region. Weighting the priorities and the measures will change in an evolving quality system. Out of the entire system should emerge the ability to monitor the overall level of quality, the areas of clinical focus (which could vary by region), and the per capita expenditures and targets for cost reductions.