Implementing a Hospital Value-Based Purchasing Program for Medicare

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Written Statement

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Hospital Value-Based Purchasing Program Implementation Plan

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Chairman Baucus, Ranking Member Grassley, and distinguished members of the Committee, I want to thank you for the opportunity to participate in this Roundtable on the Centers for Medicare & Medicaid Services' (CMS) plan to implement a value-based purchasing (VBP) program for Medicare inpatient hospital services. I am Stuart Guterman, senior program director for the Program on Medicare's Future at the Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable populations—including the elderly and disabled, who are particularly likely to have low incomes and suffer from chronic conditions and frail health. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy.

In this written statement, I will address the questions raised by Committee staff in the context of the potential of value-based purchasing and other initiatives to improve Medicare's ability to carry out its traditional role—providing the elderly and disabled with access to the care they need—while also serving as a model for improvements throughout the health system. In accomplishing these goals, Medicare must pursue policies that increase the value obtained by its beneficiaries for the $460 billion it will spend on health care services this year.[1]

<u>Question to Frame the Discussion (What are we trying to accomplish?)</u>

1. Should the purpose of a hospital VBP program be to provide incentives for quality improvement, to partially base payments on the value of care provided, or both?

Increasing value may involve improving quality at the same level of spending, attaining the same level of quality at a lower level of spending, or some combination of the two. Previous research has called attention to the shortcomings in both the quality of care and the level of efficiency not only in Medicare but throughout our health system, and it is imperative to strive for improvement along both of these dimensions.[2]

Furthermore, there is reason to believe that substantial progress in both quality and efficiency should be possible. Despite the high level of Medicare spending nationally, there is wide variation across the country in the amount that Medicare spends per beneficiary.[3] Moreover, the quality of care across areas does not correspond to the amount of spending.[4] While these patterns can reflect a variety of factors, they seem to indicate that there is room for improvement in both quality and efficiency.

The VBP should reflect a broad view of value. Under its prospective payment system (PPS) for inpatient hospital services, Medicare already rewards efficiency for individual hospital stays—hospitals that keep costs below Medicare's fixed payment rate for each type of case may retain the entire payment; but the system does not reward—in fact, it discourages—efforts to coordinate care beyond the individual stay, including follow-up care that might avoid readmissions. The Medicare Payment Advisory Commission (MedPAC) estimates that 17.6 percent of Medicare admissions result in readmissions within 30 days of discharge—which may be viewed as indicating both potential quality and efficiency problems—accounting for $15 billion in spending.[5] These figures indicate the importance of VBP efforts that go

beyond the level of individual service units like the hospital stay and consider the hospital's role in the continuum of care.

Quality Measures

2. What process should be followed to develop, test, refine, endorse, adopt, and retire quality measures used in the Medicare VBP program?

Several organizations currently play a role in the process of developing, testing, refining, and endorsing measures for value-based purchasing: the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) is responsible for certifying hospital compliance with patient safety and quality standards; the National Committee for Quality Assurance pioneered quality measurement for health plans, and has implemented provider recognition programs to help encourage quality improvement; the National Quality Forum has played a crucial role in encouraging the development of standardized measures and achieving consensus among the interested parties in both the public and private sectors; the Agency for Healthcare Research and Quality has played a leading role in consolidating existing information and translating research into practice; and CMS has developed several demonstrations to test different approaches to changing the financial incentives that hinder improvements in quality and efficiency. Several major hospital groups joined to form the Hospital Quality Alliance, which encouraged the first nationwide efforts to report standardized hospital quality measures.

Many of the current activities aimed at developing measures involve several or all of these groups, and others. The Institute of Medicine (IOM) has called for the establishment of a National Quality Coordination Board to oversee the development and implementation of a nationwide system for performance measurement and reporting, citing the need for an independent entity that can work in close collaboration with public and private organizations of payers, providers, and other interested parties.[6] One approach would be for the federal government to establish a group that includes all of the relevant stakeholders to develop standards and consensus on how to apply them, similar to the American Health Information Community, initially convened by the Secretary of Health & Human Services to encourage the dissemination of health information technology but envisioned as transitioning to a public-private partnership of interested parties.[7]

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

The types of measures used to determine hospital payments should reflect the dimensions along which improvement is desired, which I believe calls for broader rather than narrower sets of measures, drawing from all the categories mentioned in the question. Outcomes certainly are the "bottom line" in health care, and measures of global outcomes, like mortality rates, as well as intermediate outcomes, like readmissions, should be included. However, relying solely on outcomes may make the VBP system vulnerable to inappropriate incentives, such as avoidance of sicker patients—even the most sophisticated mechanisms available to adjust for the risk of poor outcomes for individual patients may not be good enough to deter the perception that such risks are to be avoided rather than managed. Structure and process measures are much less susceptible to these shortcomings, and in addition provide a more specific message to providers about what is expected of them, in terms of "action items". Great care

should be taken, however, to ensure that these measures of structure and process are credible and clearly related to better outcomes.

It also is extremely important to emphasize the role of the patient in the healthcare delivery process, and not to reflect the patient experience in the definition of value would be a serious omission. An additional aspect of patient experience that is important to consider is disparities in care—measures (on both the provider and patient level) that reflect the desire to decrease or eliminate disparities would be useful to include in a VBP system.

Finally, as I mentioned earlier, we should strive for improvement in both efficiency and quality—quality without efficiency is unsustainable, and efficiency without quality is of no use.

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

It is important to align incentives across the health care system, so that the various providers of care do not receive conflicting signals; this is particularly true for the hospital, where physicians are the primary decision-makers as to which services are provided. The IOM recommended that reward pools for different providers be aggregated to some extent to allow for shared accountability and encourage more coordinated care.[8] In any case, incentives ought to be consistent and measures should take into account the potential for diffuse or conflicting signals as to appropriate care.

Performance Standards

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

Paying for high performance offers the advantage of rewarding achievement, which clearly is desirable. However, such systems tend to reward previous performance, rather than improvement.[9] Establishing meaningful minimum thresholds of performance rewards all providers that achieve that level, but again tends to reward previous performance; moreover, identifying an appropriate minimum level is difficult, certainly until there is a sufficiently reliable evidence base, and there is the risk that mediocre, rather than outstanding, levels of quality will result. On the other hand, rewards based solely on improvement favor providers with historically poor performance.

The IOM recommended a pay-for-performance program that initially rewards both providers with significant improvements in performance and those with high levels of performance.[10] A combined approach offering rewards for attainment of an absolute level of performance, relative performance, and improvement relative to previous periods—such as the one being used in the extension of the CMS/Premier demonstration—may be the best way to balance the offsetting advantages and disadvantages of each individual approach.

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

Both the measures to be used and the thresholds for rewards should be evaluated continuously and re-visited each year by the entity responsible for overseeing the system—whether it is CMS or another existing organization, or a new entity specifically created for that purpose.

7.   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?

One advantage to payment for individual measures is that the reward is more closely tied to the behavior that it is intended to encourage. However, this type of approach runs the risk of over-emphasizing the individual measures, leading providers to focus on how they perform specific services and potentially distracting them from the message that overall performance needs to improve in the context of a more cohesive, less fragmented healthcare delivery system. For this reason, the payment system should be administered on a broader basis, with individual measures combined into aggregate scores.

Public reporting could be done on a somewhat less aggregated level, balancing the desirability for specific information against the confusion that might result from a large number of potentially conflicting scores for every provider. Information on individual measures should, however, be shared with individual providers, to encourage targeted performance improvement efforts.

Structure of Incentives

8.   Should incentives be applied to services related to certain measures, all DRGs, or base payments?

The CMS/Premier demonstration uses composite measures applied to each of five conditions, defined by groups of DRGs. That approach seems to work well in the context of that project, but there are certain measures (such as broader quality-related measures that are not condition-specific, or overall efficiency measures, which could not be appropriately applied to specific conditions) that probably would be best applied at the provider level. The use of a combination of condition-specific and provider-level measures also might help reduce the tendency for certain sub-groups of provider staff (such as cardiac surgeons) to assert their claim to bonus payments that are apparently generated by the types of services they provide to the types of patients they treat.

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

In the CMS/Premier demonstration, a potential bonus of 1 or 2 percent appears to be effective in spurring improvement—I believe that providers don't need to be bribed to improve performance (in which case it would take a substantially larger amount to change their behavior), but only need to be given a signal that they will be recognized and rewarded for doing so. The 2 to 5 percent proposed by CMS seems reasonable to me—the VBP might start with a smaller amount while additional measures are developed and validated and the payment mechanism sorted out, and then increase as the system matures. Also, to the extent that other payers also participate in the VBP system, a smaller amount from each payer might be required to elicit the desired effect.

10. 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?

Under the approach described in my answer to question 5 above, the impact on payments would be a blend of absolute and relative performance and degree of improvement. That way, all hospitals have a reasonable chance for extra payments. If, in addition, special considerations are built into the VBP

mechanism, the impact on hospitals would better their circumstances, and additional technical advice could be provided to encourage improvement.

<u>Implementation</u>
11. What kinds of hospitals should not be included?

All hospitals should be included in the VBP. There may need to be certain adjustments to the set of measures used for different groups of providers (such as safety net or rural hospitals) or to the standards that are used to determine the payments. But an appropriately structured VBP system should be able to balance the impact of variations in the circumstances faced by different groups of providers. In addition, Medicare might use the Quality Improvement Organizations (QIO) in each area to work with providers in adverse circumstances to help them improve.

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

Hospitals have been submitting a set of quality measures to CMS since 2004, beginning with a “starter set” of 10 and expanding to the current set of 24 as of June 2007, so the stage is set for immediate implementation of those measures. As additional measures are developed, they can be added to the set that is used to determine payment. As more and broader measures are added, a transition period can be provided to ensure that they can be appropriately reported and benchmarked, and the amount of payment that depends on performance can be correspondingly increased.

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

Essentially all hospitals paid under Medicare’s inpatient hospital PPS currently report the data necessary to at least initially populate a VBP system, so the incremental cost should not be great. As the system expands and both hospitals and CMS make more use of the data for their quality improvement activities, the cost of implementation may increase. It may be appropriate for the Government Accountability Office (GAO) to study this issue so that the potential need for additional resources can be assessed.

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

Implementation of a VBP system for hospitals should include a reliable mechanism for auditing and verifying the results, and CMS should have sufficient resources to conduct such activities. Hospitals should have the ability to challenge the results, subject to explicit and consistent criteria that are designed to ensure the quality of the data and minimize the length of any settlement process.

15. How should the program be monitored on an ongoing basis?

Transparency is the key to the credibility and effectiveness of any VBP system. To the extent possible, data should be available for independent analysis, and the GAO should conduct an audit of the system every couple of years.

Notes

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[3] A.B. Martin, L. Whittle, S. Heffler, M.C. Barron, A. Sisko, and B. Washington. “Health Spending by State of Residence, 1991-2004” *Health Affairs* Web Exclusive (18 Sep. 2007):w651-w663.
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[10] IOM. *Rewarding Provider Performance*.