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Statement of Premier Healthcare Alliance
Senate Finance Committee Roundtable on the
CMS Value-Based Purchasing Plan for hospitals
March 6, 2008

On the behalf of our 1,700 not-for-profit hospitals, I, Rick Norling, president and CEO of the Premier healthcare alliance, am pleased to be here to participate in the Senate Finance roundtable on value-based purchasing (VBP) for hospitals.

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Premier supports many elements of the approach to value-based purchasing that was presented in CMS' November 21, 2007 document *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program*, but numerous critical details were left open for discussion. Premier appreciates the opportunity to offer views, based on our experience with the Hospital Quality Incentive Demonstration (HQID) pay for performance (P4P) project, regarding how a Medicare VBP plan can best be designed to achieve both better outcomes for patients and greater hospital efficiency.

While we are pleased that the Administration's budget for fiscal year 2009 includes a legislative proposal to establish incentives for hospitals to improve and attain high-quality care, we are highly concerned that VBP is intended to generate $1.65 billion in savings to the Medicare program over five years. Rather than serving as a means of cost-saving to the government, VBP must be used to drive change and create incentives for continuous quality improvement. We urge you to ensure that any savings achieved by hospital VBP through quality gains be *reinvested* in hospitals participating in the program. For example, any "unallocated" funds that are withheld from hospitals that did not achieve the required level of performance or improvement should stay within the VBP system and be distributed to hospitals that have earned an incentive payment to assist with additional performance improvement projects.

<u>Quality Measures</u> (1) Chart/attachment

- Quality measures used for VBP should be evidence-based and statistically valid, endorsed by the National Quality Forum (NQF) and recommended for use by the Hospital Quality Alliance (HQA).
- Initially, the process measures for four specified conditions/performance areas should be used in VBP: acute myocardial infarction (AMI) (excluding 30-day mortality), heart failure (excluding 30-day mortality), pneumonia, and Surgical Care Improvement/ Surgical Infection Prevention (SCIP/SIP). The specific initial performance measures should be those identified in the CMS *Report to Congress*, shown in the attachment to this statement.
- More experience needs to be obtained with the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) before adding it to the VBP program.
- The 30-day mortality measures also should be excluded from the initial measures as these measures do not currently provide adequate feedback for hospitals to evaluate their performance. Because they require data on post-hospital mortality, these

- measures can only be calculated by CMS and CMS only posts performance results on an annual basis. In addition, the feedback indicates if a hospital is performing "as expected," "better than expected," or "worse than expected." These categories do not provide enough information to be incorporated effectively into a P4P measurement and do not give hospitals a clear indication of how they are performing.

Future Measures

- For FY 2010 and beyond, CMS should be directed to work with consensus organizations to develop new measures in the following areas: efficiency, patient outcomes, emergency care, care coordination, patient safety, structural measures such as use of health information technology, and performance areas where gaps are identified and new measure development is needed. All new measures should undergo a preliminary data submission period without either public reporting or the application of performance-based incentives. Following this submission-only period, measures should be publicly reported for a period before they are included in the VBP incentive program. As the majority of past experience has been with clinical process measures, alternative measurement methodologies may need to be explored for outcome and patient experience of care measures. All outcome measures should be appropriately risk-adjusted to avoid creating disincentives for hospitals to treat sicker patients.
- Candidate VBP measures should be based on a set of criteria which include importance, feasibility, scientific acceptability, improvability, usability, controllability, potential for unintended consequences, and contribution to comprehensiveness. Before NQF and HQA endorsements and recommendations are obtained, hospitals could be required to submit data to CMS on new measures under consideration. These measures would not be publicly reported, but data on them would assist in the process of measure development and refinement, as well as provide hospitals with experience in using the measure.
- Measures that are "topped out" should continue to be reported and, although not included in the incentive calculation, performance should be monitored to ensure that hospitals hold the performance gains. If hospitals fail to meet the performance thresholds on "topped out" measures then penalties could be assessed.
- CMS should be directed to periodically reassess measures to determine their appropriateness for continued use in the public reporting and VBP incentive programs. Measures would be retired from the VBP program over time for a variety of reasons, including changes in science and changes in policy objectives.
- Legislation should direct CMS to evaluate the adequacy of measures in the different clinical areas, including their validity for the purpose of creating a composite measure for the clinical area. CMS should be directed to consider how to report composite measures for clinical areas with a small number of measures. These requirements are important in view of CMS decisions to suppress measures that have changing evidence or that are considered to be "topped out."

Aligning Hospital and Physician Quality Incentives

Legislation should direct the Secretary to assure alignment of physician quality measures applicable to hospitals and other providers. Such alignment is essential for the achievement of quality goals by hospitals and other providers. The Secretary should be directed to engage quality measurement development organizations in the development of complementary quality measures for physicians, hospitals, and other providers, unless there is evidence that a complementary quality measure in a particular circumstance would not improve the quality of patient care. In addition, in its endorsement of future measures, the NQF should be expected to ensure the alignment of physician and hospital incentives. Moreover, we believe that hospitals should be able to share payments made from a bonus pool created from savings to Medicare with physicians based on their performance to the metrics and number of patients treated.

Public Reporting

- Public reporting should continue as an important tool for quality improvement and as a process through which hospitals can gain experience with new measures, prior to their implementation in VBP.
- Information should be displayed to facilitate fair and accurate decision-making by patients and to avoid simplistic and misleading hospital rankings. While such an approach might grab news headlines, it does not offer much of value to consumers looking for a good hospital for their specific needs, nor does it provide the type of information that hospitals need to improve their quality of care. Such lists also can be misleading and unfair to hospitals and could undermine support for Hospital Compare. CMS should be prohibited from publishing or posting lists that attempt to rank hospitals based on their overall performance.
- Legislation should direct the Secretary to improve the current Medicare Hospital Compare Web site to make it user friendly and flexible to meet different users' needs. CMS should offer a Hospital Compare Web site that allows users to customize their queries relatively easily. Legislation also should direct CMS to develop a series of standard public reports responsive to the different needs identified by various stakeholders, including hospitals, consumers, purchasers, researchers, and policy makers. To have information that is valued by stakeholders, CMS must invest significant time and resources to learn what information is useful to them, as well as what format best facilitates its use. For example, hospitals may want to know how they compare with other hospitals in their area and/or of their type. They may want to know the clinical areas or conditions or specific measures where they have the greatest need to improve. Beneficiaries and consumers, on the other hand, may want information that is targeted to helping them choose a hospital. For example, beneficiaries might benefit from a report that highlights the measures or conditions for which good performance is most related to clinically important outcomes.

Appropriate Care Score **(2) Chart/attachment**

An alternative measure of hospital performance is the "Appropriate Care Score," which considers the extent to which patients are reliably receiving evidence-based care. Specifically, this measure looks at the percentage of the time a hospital provides a patient with all of the appropriate measured actions.

In the HQID project, we have seen improved performance in the Appropriate Care Score over time for all clinical areas (see attached chart). The greatest improvement was for pneumonia, for which the median hospital Appropriate Care Score increased from 22.3 percent during the first quarter of the project to 90.1 percent for the 15th quarter. Similarly, the median hospital Appropriate Care Scores rose from 30.0 percent to 94.3 percent for heart bypass surgery and rose substantially for the other conditions as well. Research by Premier has found that hospitals achieving a 100 percent appropriate care score have the greatest reductions in mortality, complications and costs. We believe CMS should publicly report hospitals' Appropriate Care Score and consider this measure for the evaluation of process measures in the future.

Performance Standards

- Hospitals' performance scores should be determined using the scoring methodology described in the *Report to Congress*, except that performance scores should be calculated separately for each specified condition rather than using a single overall performance score for each hospital.
- As specified in the CMS plan, performance scores on each measure should consider both hospitals' attainment level and amount of improvement, with the final score for each measure reflecting the higher of the attainment or improvement score on the measure.
- Performance scores on the individual measures should be weighted equally and combined to determine a performance score for each specified condition or performance area.
- In addition, a new Appropriate Care Score measure should be developed for reporting and later for use in the performance scores for process measures.

- The CMS VBP framework includes: 1) a floor performance score, or threshold, the minimum score below which a hospital would not be eligible for any performance-based payment, and 2) a full-incentive benchmark, the performance score that must be achieved for a hospital to earn the full value-based payment at risk. The threshold should be set at zero so that all hospitals, no matter how low their current performance, have a financial incentive to improve. The incentive to earn back *all* funds at risk will be an additional boost to promote improved performance for lower-performing hospitals.
- Benchmark values should be set such that every hospital can receive full reimbursement provided they have reasonable performance. Benchmarks should be set based on real world experience with the measures, taking into account historical performance levels, improvement rates, and the opportunity for continued improvement.
- Aggregate hospital payments should remain unchanged and value-based payments should be "instantaneous" – that is, there would not be a set-aside in one year with a delay in transferring value-based payment until the next year. Value-based payments in a year should be based on hospitals' performance in a prior period, with the shortest practicable time lag.
- Benchmark values should be announced such that hospitals have time to impact their performance to meet the benchmark during the measurement timeframe. Given the built-in data lags, benchmarks should be created using the most recent data available and announced for performance measurement two years in advance in order to give hospitals time to implement performance improvement efforts. That is, a benchmark announced in the fiscal year 2009 proposed rule would be based on data from fiscal year 2008 and applied to payment in fiscal year 2011.
- The full incentive benchmark should be phased in so that hospitals have time to make the changes necessary to improve quality and still achieve a full payment, with benchmarks recalibrating over time as hospitals gain experience and make improvements.
- Payment reductions arising from any hospital not achieving the full-incentive benchmark would be used to make bonus payments to high-performing hospitals.
- At the time of performance measurement, if a reasonable proportion of hospitals fail to reach the benchmark, the benchmark should be re-evaluated to determine whether extenuating circumstances such, as measure definition changes, prevented hospitals from reaching the benchmark.

Structure of Incentives

- Up to 2 percent of base DRG payments in the Medicare inpatient hospital acute care prospective payment system should be subject to the VBP program. As envisioned in the CMS plan, payments subject to the VBP program become "at risk." How much of the at-risk payments a hospital receives would be dependent on its performance on designated quality measures.
- Only payments in the DRGs pertaining to the performance measures should be "at risk," not an across-the-board application to all DRGs.
- Only base DRG payments, including DRG payments related to operating costs excluding adjustments for disproportionate share, indirect medical education, and outlier payments, should be at risk. Capital payments should also be excluded.

Implementation -*Transition from Pay for Reporting* – **(3) Chart/attachment**

The attached chart summarizes the phase-in transition to VBP. Once a new full-incentive benchmark performance score is announced, all hospitals would have two years to meet or exceed it. Payment reductions arising from any hospitals not achieving the full-incentive benchmark would be used to make bonus payments to high-performing hospitals.

Small Hospitals

To provide for successful incentives, a VBP program relies on measurement of a sufficient number of cases to be meaningful. CMS should work with representatives of small hospitals, both urban and rural, to

determine the best way for these hospitals to participate in quality improvement efforts.

Additional Incentive Pool
Each year an independent analysis should be conducted of the actuarial value of the performance improvement by hospitals in the program. If savings are identified from improvement in quality and efficiency, these funds would be used to establish a bonus pool to fund additional incentive payments. These additional incentive payments to the hospital could be shared with physicians based on actual, measured quality of care delivered and volume of patients treated.

Role of Quality Improvement Organizations (QIOs)
Hospitals below the established threshold should receive priority assistance from the QIOs for quality improvement. QIOs should be evaluated and contracts renewed based on how well hospitals improve in their quality scores. QIOs are independently organized and vary across the country in their effectiveness. CMS should also allow hospitals to seek improvement through alternative private organizations that support hospital quality improvement.

Annual Report to Congress
An annual report on the performance of the VBP program and recommendations on steps to improve the program would be delivered to Congress. The report would identify the benefits and improvements to health and healthcare resulting from the implementation of the program, along with any unexpected consequences.

Data Submission, Validation, Reconsideration and Appeals **(4) Chart/attachment**
- The 4.5 months timeline for data submission and validation currently used by CMS for pay for reporting should be retained, and CMS should report to Congress on whether it is practical for CMS and hospitals to reduce this timeline to 60 days.
- CMS acknowledged in its *Report to Congress* that hospitals and vendors make occasional errors during the submission process and stated that, for VBP, a resubmission period of 30 days after the close of each data submission period could be provided. Resubmissions would not be allowed once the data is locked to determine incentive payments. CMS should be directed to implement a resubmission period to provide for the most accurate data being used for incentive payments. A timeline chart is attached.
- The validation process should be based on the proposed plan developed by CMS. This plan selects hospitals on both a target and random basis and includes validation at the measure level.
- With the implementation of any new program and new performance measures, there is an unavoidable learning curve as hospitals gain experience with the new tools and the data collection process. Similarly, staff members of the clinical data abstraction center (CDAC) with responsibility for the data re-abstraction for validation also experience a learning curve. Recognizing this reality, legislation should direct CMS initially to utilize re-abstraction and validation as a learning tool without establishing standards, such as a minimum validation threshold, for new measures above what is being collected under pay-for-reporting.
- Legislation should direct CMS to establish a reconsideration process that is straightforward, transparent and timely. Hospitals would be given clear guidance on how to submit their appeals, and CMS would establish an expedited appeals process.
- CMS should be directed to provide hospitals with the opportunity to review their data, prior to public posting or use in the VBP incentive program, in a manner similar to the current pay-for-reporting process.

CONCLUSION

The Premier healthcare alliance has learned firsthand through our work on the HQID project that pay-for-performance, or value-based purchasing, creates a powerful engine that can accelerate hospital performance on quality and outcomes metrics. Hospitals participating in the HQID project have shown performance gains that have outpaced those of hospitals involved in other national performance initiatives. In fact, analyses by Premier using data from the Hospital Compare program and HQID showed that participants scored on average 6.5 percent higher than non-participants when looking at a composite of 19 common measures. The average improvement from the July 2004-June 2005 timeframe to the April 2006-March 2007 timeframe was 7.8 percent for HQID participants, whereas the average improvement for non-participants was 5.6 percent. In addition, the gap in performance from top to bottom performers is much smaller in HQID participants than non-participants. Using the April 2006-March 2007 Hospital Compare data, the HQID participants ranged from 73.7 percent to 99.0 percent on the 19-measure composite, whereas non-participants with at least 25 cases ranged from 11.2 percent to 99 percent.

Accelerating healthcare performance improvement is imperative to patients and our economy. **For this reason, we believe Congress should act now to enact a hospital value-based purchasing program.**

We believe Congress should incorporate five important design elements in establishing a value-based purchasing program. First, it must create a positive incentive to improve performance. Our experience has been that improved quality and outcomes can reduce healthcare costs over time. Therefore, while the program may have to initially reward hospital performance by using a portion of the DRG payment, we believe an annual actuarial assessment should be conducted to identify savings that will be achieved by hospitals in the long run. These savings should be used to fund a bonus pool to further drive performance improvement. Second, we believe that every effort should be made to align physician and hospital interests. CMS and the measure development organizations should work to coordinate/bring together physician and hospital measures. Moreover, we believe that hospitals should be able to share with physicians, based on their performance on quality measures, payments allocated from a bonus pool created from Medicare savings. Third, we believe Congress should set benchmarks using the evidence we have gained from the HQID project. HQID has demonstrated a realistic level of improvement for hospitals, and this performance improvement should be used to set realistic and attainable benchmarks for hospitals. Fourth, we believe value-based purchasing should be irrevocably tied to public reporting. The public reporting should be easy for patients to understand and should identify hospital performance on composite scores for each clinical condition, the same way we recommend hospitals be rewarded. Moreover, we believe that patients should also be able to see the appropriate care score, which is the hospital's level of performance in delivering ***all*** recommended quality measures for each clinical condition. All new measures should be publicly reported and tested before being used in a value-based purchasing program. Finally, we believe that performance improvement results from incentives, collaboration and sharing of best practices. QIOs should focus their efforts on the lower performing hospitals. CMS should also allow hospitals to seek improvement through alternative private organizations that support hospital quality improvement.

Additionally, Premier recognizes the importance of providing support for hospitals as part of the pay-for-performance environment. Part of the success of the HQID project and the relatively low number of participating hospitals penalized in the project's third year can be attributed to the support provided for project participants. Throughout the project, Premier has facilitated the distribution of best practices amongst all participants and provided consulting support for hospitals with lower levels of performance. Quality performance targets should be announced far enough in advance that all hospitals have sufficient time to make any changes necessary to achieve them.

Premier Research – lives and costs saved

In a January 2008 analysis, Premier has found that hospital quality continues to improve while patient mortality rates and hospital costs are declining among participants in the demonstration project. If all hospitals nationally were to achieve the three-year cost and mortality improvements found among the project participants for pneumonia, heart bypass, heart failure, heart attack (acute myocardial infarction), and hip and knee replacement patient populations, they could save an estimated 70,000 lives per year and reduce hospital costs by more than $4.5 billion annually. The 1.1 million patient records represented in this analysis encompass 8.5 percent of all patients nationally within the five noted clinical areas over the three-year timeline of this analysis. On average, the median hospital cost per patient for participants in the CMS, Premier HQI demonstration project declined by over $1,000 across the first three years of the project, whereas the median mortality rate decreased by 1.87 percent. The findings from this analysis clearly suggest that, through the reliable delivery of basic care processes, improving clinical quality and safely reducing costs is attainable for all hospitals across the country.

Attachments

1 Chart

Potential Measures for the Financial Incentive at VBP Program Start

Clinical Quality – Process-of-Care Measures		Initial Hospital Compare Inclusion
Acute Myocardial Infarction (AMI)		
AMI-1	Aspirin at arrival*	4/2005
AMI-2	Aspirin prescribed at discharge*	4/2005
AMI-3	ACE inhibitor (ACE-I) or Angiotensin receptor blocker (ARBs) for left ventricular systolic dysfunction*	4/2005
AMI-4	Adult smoking cessation advice/counseling*	4/2005
AMI-5	Beta blocker prescribed at discharge*	4/2005
AMI-7a	Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	4/2005
AMI-8a	Primary percutaneous coronary intervention (PCI) received within 90 minutes of hospital arrival	4/2005
Heart Failure (HF)		
HF-1	Discharge instructions	4/2005
HF-3	ACE inhibitor (ACE-I) or Angiotensin receptor blocker (ARBs) for left ventricular systolic dysfunction	4/2005
HF-4	Adult smoking cessation advice/counseling*	4/2005
Pneumonia (PN)		
PN-2	Pneumococcal vaccination status	4/2005
PN-3b	Blood culture performed before first antibiotic received in hospital	4/2005
PN-4	Adult smoking cessation advice/counseling	4/2005

Potential Measures for the Financial Incentive at VBP Program Start

Clinical Quality – Process-of-Care Measures		Initial Hospital Compare Inclusion
PN-6	Appropriate antibiotic selection	9/2005
PN-7	Influenza vaccination status	1/2006
Surgical Care Improvement / Surgical Infection Prevention (SCIP/SIP)		
SCIP-Inf-1	Prophylactic antibiotic received within 1 hour prior to surgical incision	9/2005
SCIP-Inf-3	Prophylactic antibiotics discontinued within 24 hours after surgery end time	9/2005

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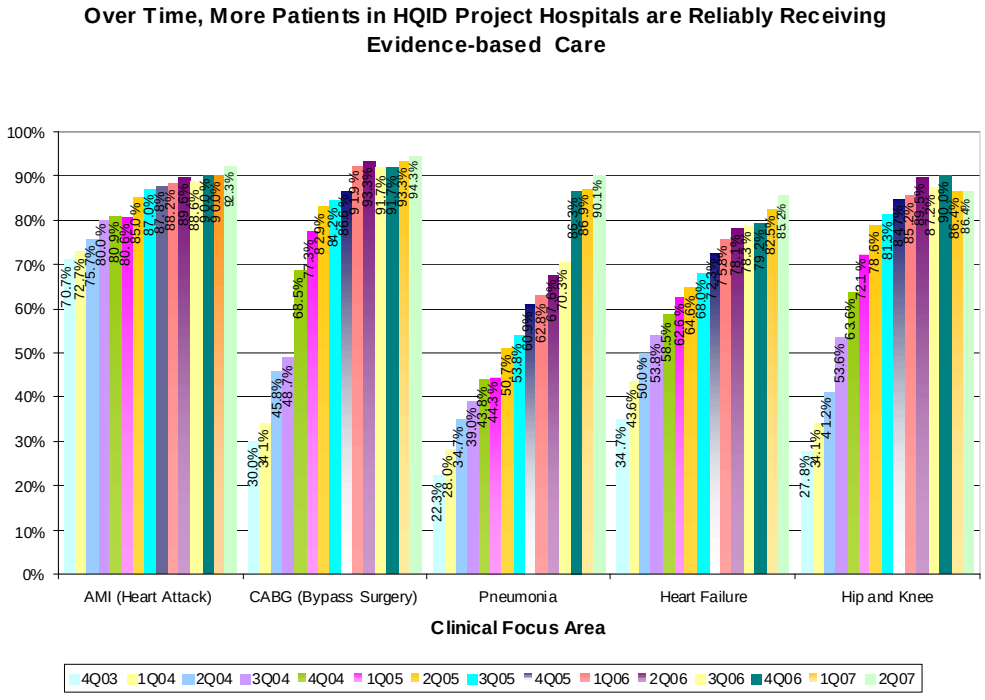
2 Chart



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3 Chart

Pay for reporting only	FY2008	FY2009	FY2010		
P4P period			**FY 2011**	**FY 2012**	**FY 2013**
Measurement period			2010	2011	2012
Full incentive benchmark performance score announced			2009	2010	2011
Data period for calculating full-incentive benchmark performance score			2008	2009	2010

FY 2008: Pay for reporting is already underway.

FY 2009: Pay for reporting would continue.
A VBP full-incentive benchmark would be announced. The benchmark would be set at a performance score level which would allow all hospitals meeting a reasonable performance expectation to receive a full payment using 2008 data. This full incentive benchmark would be used for performance measurement in 2010 and payment in 2011.

FY2010: Pay for reporting continues.
Hospital performance would be measured against the full-incentive benchmark announced in 2009, to be used for payment in 2011.
A new VBP full-incentive benchmark would be announced. The benchmark would be set at a performance score level which would allow all hospitals meeting a reasonable performance expectation to receive a full payment using 2009 data. This full incentive benchmark would be used for performance measurement in 2011 and payment in 2012.

FY 2011: Payment would be based on hospital performance in 2010 compared against the full-incentive benchmark announced in 2009 as the basis for 2011 payment.
Hospital performance would be measured against the full-incentive benchmark announced in 2010, to be used for payment in 2012.
A new VBP full-incentive benchmark would be announced. The benchmark would be set at a performance score level which would allow all hospitals meeting a reasonable performance expectation to receive a full payment, using 2010 data. This full incentive benchmark would be used for performance measurement in 2012 and payment in 2013.

FY 2012: Payment would be based on hospital performance in 2011 compared against the benchmark announced in 2010 as the basis for 2012 payment.
Hospital performance would be measured against the full-incentive benchmark announced in 2011, to be used for payment in 2013.
A new VBP full-incentive benchmark would be announced. The benchmark would be set at a performance score level which would allow all hospitals meeting a reasonable performance expectation to receive a full payment using 2011 data, to be used for performance measurement in 2013 and payment in 2014.

FY 2013 and beyond: Payment would be based on hospital performance in the previous year measured against a VBP full-incentive benchmark announced two years earlier. Each year, hospital performance would be measured against the full-incentive benchmark announced in the previous year, to be used in

payment in the following year, and a new VBP full-incentive benchmark would be announced for use in two years. The benchmark would be set at a performance score level which would allow all hospitals meeting a reasonable performance expectation to receive a full payment, using the most recent data.

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4 Chart