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Statement
of the
American Hospital Association
before the
Committee on Finance
of the
U.S. Senate

"Roundtable to Discuss the Centers for Medicare & Medicaid Services' Hospital Value-based Purchasing Program Implementation Plan"
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Good morning, Chairman Baucus, Ranking Member Grassley and distinguished members of the committee. I am Thomas M. Priselac, president and CEO of Cedars-Sinai Health System in Los Angeles and chairman-elect of the American Hospital Association (AHA). On behalf of the AHA's nearly 5,000 member hospitals, health systems and other health care organizations, and its 37,000 individual members, I appreciate the opportunity to share with you and your colleagues the hospital field's views on the Centers for Medicare & Medicaid Services' (CMS) implementation plan for a Medicare value-based purchasing program for hospitals.

Hospitals are committed to improving the quality and safety of the care that they provide every day and pioneered the creation of the Hospital Quality Alliance (HQA) to bring transparency to their efforts. The HQA is a voluntary reporting initiative in which hospitals pledge to provide information on the quality of care for selected clinical topics and to use the collected information to inform their performance improvement efforts. The data is collected and shared publicly on the *Hospital Compare* Web site in a way that the public can understand and that hospitals can use to drive performance improvement.

Hospitals' experiences with the HQA and other public and private quality initiatives have led to the creation of a consensus set of principles that we believe any pay-for-performance system, including CMS' proposed value-based purchasing system, must adhere to.

PRINCIPLES FOR REWARDING PERFORMANCE EXCELLENCE

The following principles reflect the hospital field's view of how pay-for-performance approaches should be shaped to be fair and effective. They are intended for use in leading and guiding discussions with payers – Medicare, Medicaid and private insurers – about workable and unworkable aspects of proposals to reward hospital performance.

Hospital, physician and other providers' incentives should be linked. To be effective, pay-for-performance approaches must align hospital, physician and other providers' incentives, encouraging all to work together toward the same goals of improving quality and patient safety, providing both effective and appropriate care and creating better health outcomes. Measures and systems for collecting and reporting performance information for all types of care providers should be created. Special attention should be paid to creating performance measures across different providers that drive toward common improvement goals and link desired performance changes.

Incentive approaches should be developed collaboratively, involving all stakeholders. Payers should be encouraged to come together with hospitals and physicians in collaborative efforts to structure payment incentive approaches. Together, payers, employers and providers should develop shared objectives, measures and payment methods and seek to minimize multiplicity of requests for information and data.

The goal of incentive approaches should be to improve performance. The use of payment to change incentives in today's health care system should reward providers for demonstrating excellence in *improving quality and patient safety and providing effective care*. Incentive-based payment approaches should not be used as further cost-cutting measures for payers. Payment approaches should not reward performance based on the cost of the care provided, as costs vary based on things other than performance (e.g., patient case mix, teaching activity, research).

Incentive approaches should provide rewards that will motivate change. Rewards provided through incentive-based payment approaches should be significant enough to motivate change in the behavior of providers without placing too much at risk. In setting the amount of performance rewards, payers should consider the costs to providers of implementing such approaches and amounts that would truly allow for reinvesting in performance improvement.

Incentive approaches should be implemented incrementally. There has been little well-designed evaluation of pay-for-performance approaches and existing research shows mixed results. In most approaches, the driving element behind performance improvement cannot be identified. As payers continue to explore this concept, it should be phased-in to allow continued testing of concepts as they are tried.

Quality improvement and quality attainment both should be rewarded. The purpose of incentive-based payment approaches should be very focused on *improving quality and patient safety and providing effective care*. A program that rewards only high performance may discourage lower performers from engaging in quality improvement efforts. In contrast, a program that rewards only for improvement can direct resources toward providers that may be more in need of those resources, but could ignore providers that have already attained exemplary performance. A pay-for-performance program should provide incentives to providers for both attainment and improvement to reward a broad group of providers for their efforts.

The measures used to assess performance should be developed in an open and consensus-based process and selected to streamline performance measurement and reporting. The quality measures used in a pay-for-performance system should be developed through an open, transparent and consensus-based process. As a result, only measures that have been endorsed by the National Quality Forum (NQF) should be included in such a program. Additionally, in order to streamline measure sets, decisions on which measures to include in the pay-for-performance program should be derived from measures selected for reporting by the HQA.

The measures used to assess performance should be evidence-based, tested and feasible. The quality measures used in a pay-for-performance system should be evidence-based and statistically valid. To assist the process of measure development and refinement, as well as to provide hospitals with experience in using the measures, measures should be extensively tested among a broad group of hospitals before they are included in a pay-for-performance program. Only those measures that have been shown to be highly valid and reliable during field-testing should be used.

The measures should accurately recognize differences among hospitals and differences among the patients they serve. Measures should be selected to ensure that all hospitals have an opportunity to participate and succeed without bias or disadvantage. Measures with built-in biases (e.g., Medicare spending/payment measures) should not be used. Hospitals should be rewarded or not based on their own individual organization's performance.

Efforts should be taken to ensure that the measures used do not institutionalize existing care disparities. The measures used to determine rewards in a pay-for-performance system should be crafted with appropriate representation of our increasingly diverse population and should be relevant to all patient populations.

CMS' PROPOSED VALUE-BASED PURCHASING PROGRAM

As required by the *Deficit Reduction Act of 2005* (DRA), the Department of Health and Human Services (HHS) on November 21 delivered its report on value-based purchasing to Congress. The report was developed after CMS engaged interested parties, including hospitals and other providers, purchasers who have constructed pay-for-performance systems, the public and others.

The report lays out a variety of options for a value-based purchasing plan Medicare can use to pay hospitals, but *stops short of actually recommending a specific design that could be implemented.* For example, the report identifies a range of choices for determining which hospitals would qualify for a reward; which measures would be included in the reward plan; how much reward a hospital would receive for any given level of performance; whether clinical process measures, patient perceptions of care and other potential measures would contribute equally to the determination of whether a hospital qualifies for a reward; how the rewards would be paid to the hospitals that qualified; and what would be done with the unexpended reward pool.

Building on the Existing System. As the AHA recommended, the report suggests basing a pay-for-performance plan on the existing pay-for-reporting system. In that system, hospitals qualify for their full Medicare payment update by submitting data on heart attack, heart failure, pneumonia, surgical care and patient perception of care measures endorsed by the NQF and selected by the HQA. Other measures would be added over time, and measures might be retired when appropriate.

Program Design. To reward performance, CMS expects to use between 2 and 5 percent of current Medicare base diagnosis-related group (DRG) payments, a much larger amount than other pay-for-performance systems have used. CMS' report suggests the plan contain the following elements:

- Required reporting of data – Hospitals would be required to submit data on all of the measures for which they have relevant patients, but leaves open the question of whether all of the measures should be used to calculate whether a hospital qualifies for a bonus.

- Measures grouped to assess performance – The report suggests that the measures would be grouped into different domains: one for clinical process measures, one for patient perceptions of care, one for efficiency measures. Within each domain, each measure would receive equal weight. However, CMS suggests that Congress could choose whether each of the domains should be weighted equally or if some would be deemed more important than others.

- Qualifying for rewards – In response to comments from the AHA and others, CMS indicated that a Medicare pay-for-performance plan should recognize both high levels of achievement and substantial improvement. To do that, CMS suggests that hospitals be allowed to earn points for each measure based on a performance benchmark or on improvement they were able to achieve over their prior year's performance. The benchmark would likely be based on the previous year's performance scores for all hospitals on each measure. For example, it may be the median score of the top 10 percent of hospitals on each measure. Similarly, a threshold or minimum level of performance would be based on the prior year's distribution of scores. Hospitals whose performance score was at or above the benchmark would receive full points for that measure. Hospitals that scored above the threshold but below the benchmark would receive points based on a sliding scale.

  Hospitals also would receive points on a sliding scale based on the improvements they achieved during the course of the year. The more improvement, the more points awarded. For measures in which most hospitals are already achieving high levels of performance, referred to as "topped out measures" in the report, CMS suggests the scoring system be modified to recognize that there is very little difference among those hospitals and a different method might be needed.

The report also articulates the need to ensure a solid infrastructure for collecting and publicly reporting performance information, and for validating the data that are submitted. CMS suggests a new approach to validating the quality data that would rely on more in-depth analysis of data submissions from a randomly selected set of hospitals each year, as

well as an in-depth validation of a small number of hospitals whose data appear to be questionable based on a statistical analysis of the submissions, or on other factors.

HOSPITALS' REACTION TO CMS' PROPOSAL

The AHA supports the principle of using payment incentives to reward excellence in care. While many elements in the report could be part of a pay-for-performance plan, like building on HQA measures and rewarding high performance and significant improvement, other elements must be changed. Of greatest concern: *placing 2 to 5 percent of base DRG payment at risk for reward is excessive for an untested system.* In addition, because HHS outlines options rather than recommendations, it is difficult to assess the plan's impact on communities, patients and hospitals.

While we recognize that value-based purchasing may hold merit to help improve hospital performance, we urge Congress to move forward cautiously, mindful of unintended consequences and that there is no simple resolution to improving health care quality. Past initiatives, including the implementation of the inpatient prospective payment system and the formation of quality improvement organizations, were expected to resolve hospital quality issues, but more work remains to be done.

The AHA urges Congress to think carefully when developing and implementing a program to avoid any unintended consequences that may adversely affect hospitals and the patients they serve. This is particularly important as a number of major Medicare payment regulatory changes are expected in fiscal year 2009, including continued transition to cost-based weights, a possible new classification system to address patient severity, implementation of the DRA provision on healthcare-acquired infections and potentially significant wage index changes. The additional implementation of a value-based purchasing program will be challenging and resource intensive for hospitals.

CONCLUSION

The hospital field believes that using incentives to reward performance excellence is an important concept worth exploring. More can and should be done to make health care more efficient and of higher quality.

However, pay-for-performance is a policy idea that is still largely untested and unproven. Any such effort must be based on measures that are standardized, meaningful, accurate and reliable. And the goal must be to improve performance, not cut the budget. In remarks made as the report was released to the public, CMS Acting Administrator Kerry Weems indicated that Congress could achieve budget savings by retaining some or all of the unspent reward funding, which would mean that implementation of the pay-for-performance plan could create a "backdoor" budget cut for hospitals. Any perception that these efforts are about budget cutting and not performance improvement will sour the kind of change that everyone would like to see in care delivery.

Mr. Chairman and distinguished committee members, thank you for your time. We look forward to working with this committee and staff to forge ahead toward a shared goal: improving the quality of American health care.