American Hospital Association

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The Honorable Charles Grassley
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Grassley:

On behalf of our 4,800 hospital, health care system, and other health care provider members, and our 33,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide additional feedback on the Medicare Value Purchasing Act of 2005 (S. 1356). We applaud your vision and leadership in building on current quality improvement efforts to reward excellence in care.

As we stated in our recent testimony before your committee, we share your goal and commitment to improving the quality of care for all Americans. We would like to provide some suggested improvements to the legislation.

We are very concerned that the legislation would require that reward payments be held until the following year. This penalizes hospitals by reducing payments in the first year, and not rewarding hospitals until the following year. If the incentive structure is to work, the money should be paid out as a reward for services rendered in that same year. Incentive programs with a delayed payout are not as successful as those that provide the reward more immediately. Therefore, we urge you to shorten the gap between the time the funds are collected and when reward payments are made.

As you know, in 2003 the AHA supported a provision in the Medicare Modernization Act (MMA) that tied the hospital inpatient update to the reporting of 10 quality measures. At that time, more than 2,000 hospitals were already reporting this quality information as part of the Hospital Quality Alliance (HQA), a very effective public-private partnership that is not only making credible information available to the public but also reducing the measurement "babble" that had been generated by a large variety of separate organizations asking hospitals to produce quality improvement information. To date, nearly 4,200 hospitals – more than 99 percent of all eligible Medicare Prospective Payment System hospitals and nearly 400 Critical Access Hospitals – have committed to this process and publicly shared their data.

We strongly believe in the value of sharing quality date with the public. Because of the success of the HQA, we believe such sharing is best done as a public-private partnership project. We urge you to amend the hospital-related provisions in S. 1356 that could result in a parallel and duplicative quality measurement system and instead specify that the Secretary of Health and Human Services be required to choose measures for pay for performance from among those used by the relevant public- private collaborative initiative for public reporting. This would reinforce the importance of public reporting and minimize data collection burdens. For hospital measures, this would mean the Secretary would select measures for pay for performance from among those used by the HQA.

To finance the payment rewards, the legislation would eventually reduce all hospital Medicare inpatient payments by 2 percentage-points. This amount is too large for the first widespread Medicare experiment in rewarding quality excellence when there are currently only three conditions that would enable a reward. We support a smaller pool of funds (1 percentage point phased-in over four years) and that funding bear a direct correlation to the percentage of cases included in the quality measures.

In addition, we are concerned that the legislation seeks to tie payments to issues, such as "efficiency," that could change incentives. We believe that pay for performance should focus solely on quality improvement. Since there is no common definition of "efficiency" of care, there would be significant confusion among providers on how to measure and achieve "cost-effectiveness." Further, what is "efficient" for one segment of the health care field may really just be a shifting of cost to another sector of care. A better approach to addressing the issue of efficiency would be to direct the Secretary to include among the measures chosen as part of the pay-for-performance plan some measures that will lead to higher quality and improved efficiency. For example, some measures might assess whether the care that would likely prevent harmful and potentially costly complications in care was provided. If performance as assessed by these measures were improved, complications would be reduced, and so would costs.

While reporting under the bill is voluntary, the legislation provides that hospitals that do not report quality indicators would be penalized with a 2 percentage-point reduction in their annual market basket increase. This penalty is too great. A reduction of market basket minus 0.4 percentage-points was included in MMA for hospitals choosing not to report quality measures. It was sufficient to encourage virtually every eligible hospital to participate. With such an outstanding response rate, we see no reason to increase the amount.

Finally, considering the time and effort involved in proper implementation of the pay-for-performance program, the implementation date should be modified to fiscal year 2008. This would allow hospitals sufficient time to successfully develop and administer the program.

Mr. Chairman, we again thank you for your leadership on this important issue, and we remain committed to working with you and staff to forge ahead toward our shared goal of improving the quality of care for all Americans.

Sincerely,

Rick Pollack
Executive Vice President