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January 24, 2007

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Ref: Issue Paper on Medicare Hospital Value-Based Purchasing Plan Development

Dear Ms. Norwalk:

The American Hospital Association (AHA), on behalf of our approximately 5,000 hospital and health system members, and our 37,000 individual members, appreciates this opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) issue paper on "Medicare Hospital Value-Based Purchasing (VBP) Plan Development." We applaud your efforts to reach out to stakeholders early in the process to develop a VBP program, and gladly share with you our initial reactions and suggestions.

The *Deficit Reduction Act of 2005* (DRA) called on CMS to develop a value-based purchasing program – also known as pay-for-performance (P4P) – for Medicare payments to subsection (d) hospitals (subsection (d) hospitals include acute care, long-term care, rehabilitation, psychiatric and children's hospitals, but not critical access hospitals). The goal of VBP is to improve quality and efficiency through financial incentives. While the legislation discusses program implementation beginning in fiscal year (FY) 2009, actual implementation of the final plan first will require statutory authority from Congress and the development of regulations. We are pleased that CMS has indicated that if Congress grants the agency with authority to move forward, it would issue proposed regulations so that affected parties have another opportunity to offer comments before implementation. Additionally, CMS indicates it plans to issue a draft VBP plan no later than March 22, hold a second listening session for stakeholders on April 12 and release a final VBP plan by June.

America's hospitals are committed to improving quality of care and patient safety as well as to achieving better health outcomes. We are dedicated to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients. In fact, as a founding member of the Hospital Quality Alliance (HQA), the AHA has been working with hospitals to share with the public reliable, credible and useful information on hospital quality.

VBP may hold merit as a future form of payment to help improve hospital performance; however, we urge CMS to move forward cautiously. As your issue paper acknowledges, the development of an incentive-based program is extremely complicated. The AHA is concerned that many P4P approaches to date have resulted in payment penalties, inequities and other serious consequences that have adversely affected hospitals and the patients they serve. Given the importance of such a program, we urge CMS to move at a deliberate pace. This is particularly important since a number of major regulatory changes are expected in 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 as a result of the *Tax Relief and Health Care Act of 2006*. Layering a VBP program on top of these other hospital payment changes will be challenging and resource intensive.

Our detailed reactions and suggestions fall into five categories:

- program goals and design considerations
- measures
- data infrastructure and validation
- incentive structure
- public reporting

PROGRAM GOALS AND DESIGN CONSIDERATIONS

CMS has delineated six goals for the Medicare hospital VBP program:

- improve clinical quality;
- reduce adverse events and improve patient safety;
- encourage more patient-centered care;
- avoid unnecessary costs in the delivery of care;
- stimulate investments in structural components or systems – such as information technology (IT) capability and care management tools and processes – that have been proven effective in improving quality and/or efficiency; and
- make performance results transparent and comprehensive so that consumers can be empowered to make value-based decisions about their health care and to encourage hospitals and clinicians to improve the quality of care.

CMS has suggested that health IT adoption be a goal of VBP. The AHA believes that a VBP program should encourage care processes and care improvement, rather than the tools used, such as health IT applications, to get there. For example, while barcoding for medication administration could decrease medication errors, other mechanisms, such as hiring more nurses or having dedicated pharmacists on patient units, also could limit errors and improve care. While we support more rapid adoption of IT, VBP payment systems should reward the end product – better patient care. Hospitals are diverse organizations – varying from large academic centers to small, rural facilities – CMS must allow them the flexibility to identify how they best can achieve higher quality patient care.

Also in its issue paper, CMS identifies a number of overarching principles it plans to adhere to in designing the Medicare hospital VBP program. The majority of these principles are reiterated in

our following four categories, where we provide more detailed comments. However, we ask CMS to consider adding another principle. The AHA believes any VBP program adopted by the agency should link hospital and physician incentives. To be successful, the VBP program should encourage providers and practitioners to work together towards improving quality of care and patient safety. Successfully aligning physicians and hospitals – both in terms of their performance and financial incentives – will be critical.

MEASURES

Selecting Measures. The AHA supports CMS' plan to build upon the existing set of measures used in the pay-for-reporting program to select measures for the Medicare hospital VBP program. We believe it is critical that measures selected for VBP are, at a minimum, endorsed by the National Quality Forum and adopted by the HQA. The VBP initiative should reinforce national goals and efforts, and it should support and strengthen current initiatives to provide consumers with the information they need to make decisions about their health care providers. Any measures used in the VBP program must be both evidence-based and undergo the HQA's rigorous consensus-based adoption process.

However, not every measure used in the pay-for-reporting program may be an appropriate candidate for a VBP program. We support the sample criteria CMS lays forth in its issue paper that all measures selected in a VBP program be controllable, account for the potential for unintended consequences and contribute to comprehensiveness. We also suggest CMS add a criterion that the measures show a significant opportunity for performance improvement. Further, CMS should choose those measures where action by the hospital will have a substantial impact on patient outcomes. For example, smoking cessation counseling in the hospital is not linked to a significant impact on outcome but the use of beta blockers to treat a heart attack is.

The AHA supports developing a VBP program based on evidence-based process measures that indicate whether an intervention was or was not performed by a facility. In choosing these measures, every provider has the opportunity to succeed, thereby improving overall quality and patient outcomes in America's health care system. We oppose a VBP program based on outcome measures at this time. Often patient outcomes are due to circumstances outside a hospital's control, including a patient's genetics, compliance with medical directions and many other factors. It would be unfair to financially penalize hospitals for poor patient outcomes when caregivers followed all known protocols and best practices. Additionally, outcome measures need to be appropriately risk adjusted, and it is unclear whether the science is currently sufficient to enable that to be done well. If not done well, using outcome measures also could have the unintended consequence of making providers reluctant to treat the highest-risk patients.

We encourage CMS to select, when possible, those measures that would minimize the data collection burden for providers. A VBP program should work to standardize measures and data collection requirements across all payers, as well as coordinate and align with other hospital reporting requirements for other organizations, such as The Joint Commission.

Finally, the AHA urges CMS to select an appropriate mix of measures to ensure that all hospitals – even small and rural facilities – have an opportunity to participate and succeed without bias or disadvantage. If payments are reduced to all hospitals for a VBP program, then it is critical that all hospitals are able to participate in the program. Every hospital must have an equal opportunity to achieve the "rewards" offered. It will be important for CMS to select a broad range of measures. CMS also should use cross-cutting measures, such as patient experience of care.

Introducing Measures. CMS plans to develop a process of introducing measures that will allow hospitals, vendors and the agency an opportunity to gain experience before the measures are used in a VBP program. The AHA would support this process to allow all hospitals an opportunity to gain experience with data collection, submission, validation and reporting before the measures are linked to an incentive payment. We encourage the agency to provide at least a one-year notice to all hospitals so that systems and processes can be put in place, similar to CMS' decision to publish FY 2008 pay-for-reporting measures in the FY 2007 hospital outpatient prospective payment system rule.

Measure Maintenance. The current process of reviewing and modifying measures every six months is too frequent, and the AHA encourages CMS to consider extending this process to once a year. Exceptions could be made for a major clinical reason to change or suspend a measure, such as a shortage of influenza vaccines. The frequent changes to the pay-for-reporting program and its measures is causing programming problems for hospitals and their vendors, and has caused some hospitals to inappropriately be denied their payment update for 2007. Any changes to specifications should be clearly identified and communicated to both hospitals and their vendors.

Retiring Measures. We would support CMS retiring measures when significant hospital improvement on the measure no longer seems possible, or when the clinical science determines that the measure is outdated or no longer appropriate.

DATA INFRASTRUCTURE AND VALIDATION

CMS states that it intends to build on the existing infrastructure that has been developed for the pay-for-reporting program. However, based on our experiences with the HQA and Hospital Compare, we believe that important changes could be made to the current structure. Hospitals – and CMS – need a process that is simpler and more straightforward.

We are pleased CMS is accepting suggestions on how to modify its current validation process. Validating hospital data will become even more important in a VBP program, especially as the patient data collection grows and the number of measures collected increases. The current audit of five patient charts per hospital is not enough to establish the credibility of the data. More in-depth, random audits of fewer hospitals may be preferable. Given CMS' options for validating data, we suggest the agency consider an annual audit of a random sample of hospitals to

determine the overall accuracy of the data submitted as well as data quality checks to identify hospitals that appear to be outliers.

INCENTIVE STRUCTURE

The AHA is deeply concerned by CMS' statement of principle that the VBP program will be applied in a budget-neutral manner. First, the hospital payment system is already under-funded. According to the Medicare Payment Advisory Commission, hospital Medicare margins were a negative 3.3 percent in 2005 and are projected to decline to a negative 5.4 percent in 2007. Hospitals should not receive less than they otherwise would have been paid in the absence of an incentive approach, and a VBP program should not be used as a further cost-cutting measure. Second, incentive-based approaches to payment should use a system of rewards – not penalties – to help change behavior. The VBP program should be financed using additional funds. Congress appears to support such an approach. The *Tax Relief and Health Care Act*, for example, provides physicians with a 1.5 percent bonus incentive payment for reporting quality information. Hospitals have been at the forefront leading quality efforts, and should not be penalized for their continued support and participation in such programs.

Distribution of Incentives. The AHA favors a broad distribution of incentive payments, especially in the beginning of a VBP program. Giving smaller payments to a larger number of hospitals, rather than larger payments to a few hospitals, is likely to engage more hospitals in improving their performance and decrease the overall financial risk of the program.

Incentive Payments. Hospitals should receive incentive-based payments for both improvements in performance as well as attaining certain performance thresholds. Rewarding quality improvement encourages all hospitals – even poor performers – to participate. This is critical, especially in the early years of the program, and it will help improve quality and patient outcomes in the system overall. Additionally, high-performing hospitals should be rewarded for providing excellent, effective care. A combination of incentive payments should be pursued.

We also encourage CMS to examine developing a VBP system based on absolute rather than relative thresholds or benchmarks. Hospitals need to know in advance the target amount they must meet to receive an incentive payment. This predictability is important in a prospective payment system, and would help ensure that all hospitals that achieve the threshold receive the incentive payment.

Patient Base. The pay-for-reporting system is currently based on all hospital inpatient discharges, not just Medicare patient discharges. We would support a VBP program that would base incentive payments on all hospitalized patients. This would not only encourage focused performance improvement across all payers, but also help low-volume hospitals obtain larger sample sizes.

PUBLIC REPORTING

The AHA supports CMS' intent to build off the existing Hospital Compare Web site for publicly reporting hospital performance under the VBP program. It makes little sense to build a parallel structure and report this data separately.

The other issues raised by CMS – what data should be reported, how results should be scored, how results should be displayed, and what information should be included to help interpret the results – are all very important questions. These questions are being deliberated by the HQA, of which CMS is a member. Because there is a science to understanding and answering these important questions, we believe that the HQA should continue to study these issues and provide its recommendations to CMS.

Thank you for the opportunity to provide our reactions to CMS' issue paper. If you have any questions, please feel free to contact me or Nancy Foster, vice president for quality and patient safety, at (202) 626-2337.

Sincerely,

Carmela Coyle
Senior Vice President, Policy

cc: Robin Phillips, Medicare Feedback Group