

**Statement for the Record
of the
American Hospital Association
before the
United States Senate Finance Committee**

“Health Care Quality: The Path Forward”

June 26, 2013

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Senate Finance Committee’s hearing on health care quality. Our statement is offered in support of improving transparency for the public, continuing and enhancing support of efforts to improve the safety and quality of the care delivered, and reduce unnecessary hospital expenditures.

IMPROVING THE QUALITY AND SAFETY OF HEALTH CARE IN AMERICA’S HOSPITALS

Approximately 10 years ago, hospitals began to voluntarily report key quality and safety data to the public. We started with 10 simple, well-defined and scientifically proven measures of heart attack, heart failure and pneumonia that were intended to grow over time to become a set of measures that provided an important window into the quality of care provided to hospital inpatients. The Centers for Medicare & Medicaid Services (CMS) linked reporting on this voluntary effort to Medicare payment incentives, and, over the course of several years, has expanded the number of measures hospitals are required to report to 54 measures as part of the inpatient quality program and 22 as part of the outpatient quality reporting program. In addition, another set of 16 measures, chosen from a list of 29 candidate measures, are to be generated from the hospital’s electronic health record (EHR) and reported to CMS by any hospital seeking to be certified as a “meaningful user” of an EHR.



These data are displayed on the *Hospital Compare* website and used by the Department of Health and Human Services (HHS) in many of its payment programs for hospitals. States, private payers and a variety of other organizations also request data from hospitals and seek to rate and rank hospitals' performance, as well as engage hospitals and their medical staffs in quality improvement efforts.

The sheer volume of measures and disparate ranking and rating efforts has become overwhelming and distracting to quality improvement efforts, with different priorities, different goals and different incentives impeding efforts to enhance the coordination of care across the continuum. A strategically designed approach that promotes better health and better patient outcomes by appropriately involving all stakeholders in the health care delivery system is urgently needed.

HOSPITAL QUALITY REPORTING AND IMPROVEMENT EFFORTS HAVE BEEN SUCCESSFUL

Hospitals began efforts to publicly provide quality information in order to share important and reliable quality information with the communities they serve, identify opportunities to improve care and be able to track their improvements. For some of the publicly reported measures, the improvement in care has been significant, as demonstrated in The Joint Commission's *Annual Report: Improving America's Hospitals*, which, in part, tracks hospital performance on the small number of critically important steps in care that research has shown to be essential in achieving the best outcomes for patients experiencing heart attack, asthma, or who are admitted for surgery. The Joint Commission data shows a composite noting how often everything that should be done for the patient was done in the right time and in the right way, with 100 percent being a perfect score. The Joint Commission's 2012 report shows:

Heart attack care performance improved from 88.6 percent in 2002 to 98.5 percent in 2011— an improvement of 9.9 percentage points;

Surgical care improved from 82.1 percent in 2005 to 97.6 percent in 2011 – an improvement of 15.5 percentage points; and,

Children's asthma care improved from 79.8 percent in 2008 to 94.7 percent to 2011 – up 14.9 percentage points.

The AHA has a multi-prong approach to helping its members improve the care they provide to patients and communities. We have been working to accelerate performance improvement through our *Hospitals in Pursuit of Excellence* (HPOE) initiative. Through HPOE, the AHA provides field-tested practices, tools, education and other resources to support hospitals' efforts to provide care that is safe, timely, effective, efficient, equitable and patient-centered.

In addition the AHA's Health Research & Educational Trust (HRET) serves as a Hospital Engagement Network (HEN), a driving force in CMS's Partnership for Patients campaign.

Through the agency's HEN contract, we assist hospitals adopt best practices with the goal of reducing inpatient harm by 40 percent and readmissions by 20 percent. HRET partners with 31 state hospital associations, who recruited nearly 1,600 hospitals for this effort. The ongoing program has seen significant quality improvements in areas such as infection control, early elective deliveries, falls, ventilator-associated pneumonia and readmissions. Here is a closer look at two areas:

Readmissions – Between December 2011 and December 2012, hospitals working through the AHA HEN reported a 14 percent reduction in readmissions, which equals an estimated savings of \$100 million. These savings benefit the government and private payers.

Early Elective Deliveries – Eliminating non-medically indicated elective deliveries before 39 weeks improves maternal and fetal outcomes. Over the course of a 12-month period (December 2011 – December 2012), participating HEN hospitals have experienced an estimated 42 percent reduction in non-medically necessary early elective deliveries at an estimated savings to the payers of \$10 million. In addition to its work through the HEN, the AHA joined HHS's Strong Start initiative to implement a policy of "hard stops" for early elective deliveries. Further, in June 2012, the AHA Board of Trustees adopted a position urging all hospitals to eliminate non-medically necessary deliveries prior to 39 weeks gestation.

Further, by using the Comprehensive Unit-based Safety Program (CUSP), which is funded by the Agency for Healthcare Research and Quality (AHRQ) and led by HRET, hospitals have improved care in several ways:

Central Line Associated Blood Stream Infections – More than 1,000 hospitals participate in the project to reduce central line-associated bloodstream infections (CLABSI). Thus far, the effort has reduced infections by 40 percent and is estimated to have saved more than 290 lives, and at a minimum \$97 million in excess costs have been averted to date.

Blood Stream Infections in Neonatal Intensive Care Units – CLABSIs also may affect infants. Frontline caregivers in 100 neonatal intensive care units in nine states relied on the program's prevention practice checklists and better communication to decrease CLABSI rates by 58 percent. During the course of the study, an estimated 131 infections were prevented, saving more than \$2.2 million.

Catheter Associated Urinary Tract Infections – Reducing complications associated with catheter-associated urinary tract infections (CAUTI) results in decreased length of stay, patient discomfort, excess health care costs and sometimes mortality. This program has enlisted more than 1,200 hospitals in 29 states, but it is too early to have data on the impact of this effort.

ACCELERATING IMPROVEMENT

To reduce the confusion caused by the multiplicity of measurement efforts and to focus attention on the critical opportunities to improve quality, the *Patient Protection and Affordable Care Act* (ACA) calls for the development of a National Quality Strategy. The law directs HHS to create a strategic plan that identifies critically important areas for improvement, sets goals and selects measures to be used in the federal programs to encourage achievement of

those goals. This plan relies on input from affected stakeholders, including hospitals, patients, purchasers, insurers and public policy experts.

The AHA strongly supports the premise of the National Quality Strategy. Our nation's health care system can be improved by focusing on aspects of care that a broad array of stakeholders believe to be important. Alignment of quality reporting and payment across care settings and programs is critically important to the long-term success and sustainability of health care quality improvement efforts, and to helping patients and the general public find the information that is important, understandable and relevant to their care.

For the National Quality Strategy to be a success there must be alignment of measures in various payment and public reporting programs using a consistent set of principles. At a time when health care resources are under intense scrutiny, the alignment of quality reporting and payment efforts across settings and programs would reduce the data collection burden and the unnecessary duplication of efforts among providers. Alignment also would help balance the allocation of limited resources between data collection and efforts to improve performance.

THE FEDERAL GOVERNMENT'S ROLE IN ADVANCING SAFETY AND QUALITY

To promote alignment and a focus of quality measurement resources across the health care delivery system, the HHS Secretary should identify three to five specific priority conditions or issues for measurement each year and use CMS's programs and other opportunities to promote improvement in care for those conditions. The conditions or issues should provide high-value opportunities to improve patient outcomes and quality of life. The expected changes in care should extend across all appropriate providers, and the strategies for improvement, measures used, and incentives offered should encourage all to work toward improved outcomes. The Secretary should ask the National Priorities Partnership to help identify these specific targets for improvement and the Measure Application Partnership to identify the most important measures, including measures of the desired outcomes, the critical changes in process, and potentially measures that would help the system to be alert for unintended consequences.

The AHA offers these proposed principles for selecting the right priority conditions and measures each year.

- Measures for CMS programs should be chosen to ensure a focus on the areas patients, providers and other stakeholders believe to be most important.
- Measures used in reporting and payment programs should be consistent with the purpose and goals of each program and the patients it serves.
- When measures used for public reporting and in pay-for-performance programs successfully encourage changes in the way care is delivered, there can be unintended, negative consequences. CMS should work with other key stakeholders to monitor for these unintended consequences and, when

appropriate, take steps to decrease the chances of negative effects from the unintended consequences.

- Measures implemented in federal programs should be reviewed and endorsed by the National Quality Forum (NQF) prior to inclusion in a federal program to ensure that each measure is important, scientifically sound, useable and feasible to collect.
- Before being used in a pay-for-performance program, each measure should be included in a national public reporting program for at least one year. In this manner, the results can be monitored to be sure that there is variation in performance; the causes for variation are identified and, if related to patient characteristics (such as severity of illness), appropriate adjustments are made to the measure; and potential unintended consequences of measurement and public reporting can be identified and addressed.
- It is important that there be carefulness in the selection of measures to ensure the providers being measured are focused on critical aspects of care that need improvement and to ensure patients can find information without being overwhelmed by data.

Linking Payment to Quality. The AHA supports the general concept of linking hospital payment to meeting performance targets on quality measures. However, we are concerned that many of the quality measures in federal pay-for-performance programs do not produce accurate performance results. (*See Attachment A, our policy paper, “Linking Payment to Quality” for more details.*)

Value-based Purchasing (VBP). Mandated by the ACA, the VBP program pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year (FY) 2013. The VBP program applies to inpatient prospective payment system (PPS) hospitals, with certain exceptions. It is budget neutral but is estimated to redistribute up to \$963 million among hospitals in FY 2013.

Post-acute VBP. The AHA is engaged in CMS’s processes to implement quality measures for inpatient rehabilitation facilities and long-term care hospitals, including the implementation of pay-for-reporting programs for both settings, which began in October 2012.

Readmissions. The ACA included a readmissions provision that imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions. This penalty program began Oct. 1, 2012 (FY 2013), with hospitals receiving a penalty of up to 1 percent of their Medicare payment. The payment penalty is based on the 30-day readmission measures for heart attack, heart failure and pneumonia.

Congress included a provision in the ACA stipulating that readmissions unrelated to the original reasons for admission or are planned should be excluded from the calculations of the

measures. CMS failed to address this requirement in the initial implementation of the penalty program. However, the agency did undertake a review of its readmission measures and has developed a list of diagnoses that, when they are the cause for the readmission, will result in the readmission being excluded from the measures. Further work is needed to augment this list, and the AHA continues to work with CMS to identify reasons for readmission that should be excluded.

Socioeconomic factors affect readmissions. In the years since the initial publication of information on readmission rates, it has become clear that those hospitals that serve poorer communities have a much greater challenge in trying to reduce readmissions. This is true because preventing readmissions does not depend solely on the actions of the hospitals. For patients to continue to improve and be able to stay out of the hospital, they need access to medications, appropriate food, primary care clinicians, home health care and other vital resources, but these resources are often less readily available in low income communities. Hospitals are part of the community of providers that helps to fill in these gaps, however, it is both unfair and counterproductive for large readmission penalties to be leveraged against the hospitals serving these communities – unfair because it penalizes the hospitals for what is truly a failure of the broader health system, and counterproductive because it takes away resources these hospitals could be using to help bolster the flagging health system in their communities. We urge Congress to direct CMS to adjust the readmission rates for differences in socioeconomic status before determining if a hospital has “excess” readmissions. The Medicare Payment Advisory Commission intends to further explore the role socioeconomic factors play in readmissions.

CAREFULNESS AND FOCUS ARE KEY

With direction from Congress, the Secretary has a unique opportunity to identify tightly scoped, actionable areas in which strong measures are available to drive improvement across care settings and programs. **The Secretary should identify the top three to five priority areas for measurement each year and implement them aggressively across the Department’s measurement programs.** By maintaining a focus on a small number of critically important changes needed across the health care system, the Secretary has the opportunity to effectively encourage quality and safety improvement across the entire delivery system, and in so doing, drive out unnecessary costs while improving the lives of those served.

Linking Quality to Payment

Background

Our nation's health care delivery system is undergoing a major transformation as reimbursement moves from a volume-based methodology to one based on value and quality. By linking hospital reimbursement to achieving positive outcomes on quality measures, the field can better align the health care delivery system toward continuous quality improvement, and provide financial rewards to providers that improve performance.

At the federal level, public reporting of quality measures was initially linked to reimbursement through the Inpatient Quality Reporting program (IQR). Authorized by the 2003 *Medicare Modernization Act* (MMA) and the 2005 *Deficit Reduction Act* (DRA), this “pay-for-reporting” program requires hospitals to report on quality measures in order to receive annual payment updates.

The Patient Protection and Affordable Care Act (ACA) significantly raised the financial stakes by creating several “pay-for-performance” programs that reduce Medicare reimbursement to hospitals that score below national performance benchmarks on selected quality measures. Some of the areas measured include readmissions, mortality, patient experience of care, and clinical process measures of heart attack, heart failure and and pneumonia care.

AHA View

The AHA supports the general concept of linking hospital payments to meeting performance targets on quality measures. **However, we are very concerned that many of the quality measures upon which federal pay-for-performance programs are based do not produce accurate performance results, making them inappropriate to use for public reporting and accountability programs. Moreover, we believe the manner in which some of the payment penalties are calculated lack fairness and equity.** To ensure federal pay-for-performance programs realize their potential, the AHA's efforts are focused on several fronts:

Value-based Purchasing (VBP). Mandated by the ACA, the VBP program pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year (FY) 2013. The VBP program applies to inpatient prospective payment system (PPS) hospitals, with certain exceptions. It is budget neutral but is estimated to redistribute up to \$963 million among hospitals in FY 2013.

The VBP program is funded by reducing all inpatient PPS Medicare-severity diagnosis-related group (MS-DRG) operating payments to participating hospitals by 1 percent in FY 2013, which is then redistributed. This payment reduction gradually increases each year, topping out at 2 percent in FY 2017 and beyond.

Calculating the VBP score. Measures must be reported in the hospital IQR for at least one year before they are included in VBP. In FY 2013, the VBP program included 12 clinical quality measures as well as the Hospital Consumer Assessment

of Healthcare Providers and Systems (HCAHPS) patient experiences with care survey. The clinical measures account for 70 percent of a hospital's VBP score and the HCAHPS survey for 30 percent. The Centers for Medicare & Medicaid Services (CMS) also established "baseline" and "performance" periods for the measures. The agency evaluates each hospital's scores in the performance period relative to both its baseline period score (i.e., "improvement score"), and to national scores during the performance period (i.e., "achievement score"). Hospitals receive the higher of an "achievement" or "improvement" score for each measure. Individual measures are assigned to one of several "domains" – including process, outcomes, patient experience and efficiency – that have a percentage weight used to calculate the hospital's total performance score. The total score is used to determine the amount of incentive payment each hospital receives.

The AHA supports the concept of pay-for-performance programs that provide incentives for both demonstrated excellence and noteworthy improvements in patient safety and effectiveness. **However, some of the measures selected for use in VBP are deeply flawed, and do not accurately reflect hospital performance.** The AHA has expressed particular concern about the following:

- *Reliability of 30-day Mortality and Patient Safety Indicator measures:* Adequate measure reliability ensures that differences in performance scores across hospitals are, in fact, due to underlying differences in quality and not just random variations in patient populations. CMS has included three 30-day mortality measures in this domain for FY 2014. In FY 2015, it will add a claims-based Patient Safety Indicator (PSI). **We have urged CMS to remove both the mortality and PSI measures from VBP until they demonstrate an adequate level of reliability.** A CMS-commissioned analysis completed in February 2012, showed that both the mortality measures and PSI measure fall well short of the reliability level required of chart-abstracted measures in other programs.¹ Even with two years of data, CMS's analysis showed that the mortality measures could not meet the "lower limit of moderate reliability."
- *HCAHPS measures:* **We believe CMS should assign a lesser weight to scores from the HCAHPS survey.** Emerging research suggests that HCAHPS scores may be impacted by the severity of patient illness more than previously thought. For example, research from the Cleveland Clinic has shown that as patient severity of illness worsens, their HCAHPS scores show a statistically significant decline. The current measures do not fully adjust for this phenomenon, meaning that hospitals may face an unfair, systematic disadvantage in VBP if they care for many severely ill patients.

¹ See http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP_Measure_Reliability-.pdf

The AHA expects that CMS will continue to propose additional measures for use in VBP over the next several years, and may retire or suspend some that have already been adopted once performance on those measures has reached a level that suggests further improvement is unlikely. **The AHA will continue to work with CMS to ensure that the measures selected for use in the hospital VBP are evidence-based, reliable and valid, and are important in improving patient outcomes and efficiency.**

Hospital Readmission Reduction Program (HRRP). The HRRP imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions. The penalty program began on Oct. 1, 2012, and can reduce hospital base Medicare payments by up to 1 percent in FY 2013. The potential penalty increases to 2 percent of base payments in FY 2014, and 3 percent in FY 2015 and beyond. The initial payment penalties are based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare IQR. **The AHA is concerned about both the readmission measures used in the HRRP, and the manner in which the payment penalty is calculated.**

The current readmission measures do not adequately adjust for socio-economic factors. All hospitals, regardless of the circumstances they face, aim to provide the highest quality of care to the patients and families that rely on them. Applying an appropriate adjustment for socioeconomic factors would acknowledge the reality that hospitals cannot always control or change structural barriers to accessing resources that can help prevent readmissions. In some cases, these barriers relate to an incomplete health care infrastructure in those communities. For example, a lack of access to primary care, mental health services, physical therapy and other rehabilitative support can affect readmissions. Other factors can include lack of transportation (which can affect access to medical care), and inconsistent access to nutritious foods. Given the financial impact of the HRRP, we remain concerned that without an adjustment for socioeconomic factors, resources will be taken away from hospitals caring for patients facing the most challenging circumstances. In recognition of these concerns, the Medicare Payment Advisory Commission (MedPAC) intends to further explore the role socioeconomic factors play in readmissions.

The measures also do not distinguish between related and unrelated readmissions, in spite of the ACA requirement that unrelated readmissions be excluded from measures used in the HRRP. The AHA successfully advocated for a provision in the law stipulating that readmissions that are unrelated to the original reasons for hospitalization or are planned should be excluded from the calculations of the measures. This distinction is important because it recognizes differences among patients served. CMS has made positive adjustments to these measures to exclude planned readmissions. Disappointingly, the agency has yet to provide a plan for excluding readmissions unrelated to the initial reason for admission.

The AHA also believes that the readmissions penalty formula imposes penalties disproportionate to the costs of excess readmissions. The formula is driven by statute and is quite complex. However, a June 2012 MedPAC analysis demonstrates that, in general, the payment penalty is the product of two elements:

- The “excess cost” of readmissions, which is the DRG payment rate for the condition in the HRRP times an adjusted number of “excess readmissions” for that condition; and
- A “penalty multiplier,” which is equal to 1 divided by the national readmission rate for the condition.²

Using the same simplified example as the MedPAC report, assume that the national readmissions rate for a given DRG is 20 percent. If a hospital has 100 admissions in that DRG, then the expected number of readmissions is 20. If a hospital had 22 actual readmissions, then the number of excess readmissions would be 2. If the base DRG payment was \$10,000, and the costs of the readmission were the same as the initial admission, then the cost of excess readmissions would be $\$10,000 \times 2 = \$20,000$. However, since there is a penalty multiplier of $1/\text{the national readmission rate}$, the penalty is actually five times greater ($1/.2 = 5$) than the cost of the excess readmissions in a given DRG, or \$100,000 in this example.

The penalty’s inverse relationship between the national readmission rate and the magnitude of penalty also may punish hospitals for making progress in reducing readmissions. Indeed, if the national readmission rate in the example above dropped from 20 percent to 10 percent, the penalty multiplier actually grows from 5 to 10. In the long run, the formula as currently constructed is unfair and counterproductive. This directly contradicts the goal of the program. In the coming year, the AHA will work with CMS and others to improve the measures used and to ensure the payment penalty is fair.

Hospital-acquired Condition (HAC) Payment Reduction Program. In the coming year, the AHA will work with CMS and others to improve the measures used, and to ensure the payment penalty is fair. The DRA requires CMS to identify HACs that are high cost or high volume or both; result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence based guidelines. Since FY 2009, inpatient hospital discharges are not assigned to a higher paying DRG if a selected HAC is not coded as present on admission (POA). HAC measures are derived from Medicare claims, and

² See http://www.medpac.gov/documents/06222012_MedPACFY2013IPPS_COMMENT.pdf.

currently include foreign objects retained after surgery, air embolisms, blood incompatibility, pressure ulcers, vascular catheter-associated infections, catheter-associated urinary tract infections, falls and trauma, and glycemic control.

The ACA's HAC payment reduction program goes one step further, applying a financial penalty to hospitals with high risk-adjusted rates of HACs in the DRA HAC policy, or any other quality measures selected by the Health & Human Services Secretary. Beginning in FY 2015, hospitals in the top quartile of national HAC rates will receive a 1 percent reduction to Medicare payments for all discharges. We expect to learn more about the program's implementation in the coming year, including what specific quality measures may be used to determine payment penalties.

The AHA has concerns about the selection of quality measures in the ACA-mandated HAC payment reduction program, as well as the fairness of the payment penalty. As mandated by the ACA, the Measure Applications Partnership recently completed its yearly review of measures being considered for several federal quality reporting and payment programs. This process provides a preview of the measures that will be included in formal rules. Many of the same measures were proposed for both HAC and VBP. **Using the same measures in more than one pay-for-performance program may subject hospitals to unfair double payment penalties. Moreover, the different constructs of the programs and the disparate ways in which good versus bad performance is identified could send potentially conflicting signals to patients and hospitals.** Indeed, a hospital's performance in one program could appear acceptable or even good, but in the other program may appear unacceptable or deserving of a payment penalty. To avoid such conflicting signals, it may be appropriate to consider giving heavier weight to a measure in one program, and removing it from the other.

The AHA also will discourage CMS from using the claims-based HAC measures currently in the DRA-mandated HAC program. These measures were considered for the VBP program and demonstrated poor reliability in a CMS-commissioned analysis. Moreover, many of the HACs, particularly retained foreign objects and air embolisms, occur very rarely. Hospitals may score in the top quartile, and be subjected to a payment penalty, if they have even one or two such events in a given year.