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December 22, 2008

The Honorable Senator Max Baucus
Chair
Senate Finance Committee
511 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Senator Chuck Grassley
Ranking Member
Senate Finance Committee
135 Hart Senate Office Building
Washington, D.C. 20510

RE: Comments on Discussion Draft Bill to Establish a Medicare Hospital Value-Based Purchasing Program

Dear Chairman Baucus and Ranking Member Grassley:

Thank you for the opportunity to comment on your discussion draft of a bill to establish a Medicare hospital value-based purchasing program for the purpose of promoting high-quality care in the inpatient hospital setting. The National Partnership for Women & Families and the Pacific Business Group on Health appreciate and applaud your continued leadership of efforts to move Medicare to purchase for higher value. Your proposal acknowledges that in order to achieve a high performing health care system, we need to reward results. We understand that while you are now asking for comments on hospital value-based purchasing, you appreciate the importance of broadly reforming the reimbursement system to support coordinated care that better manages chronic illness; adoption and use of electronic medical records and other information technologies; and use of comparative effectiveness research in health care decision-making. We are extremely pleased to see your offices put forward a draft bill that focuses on some of the issues specific to reforming the way hospitals are reimbursed, but also believe that we need to move value-purchasing beyond the "silos thinking" that is itself part of the problem. Without moving from a system that rewards volume to one that rewards quality of care, we will never achieve a health care system that meets the six goals put forth by the Institute of Medicine: safe, timely, effective, efficient, evidence-based and patient-centered. We thank you for your leadership in this area, and look forward to collaborating with you on future iterations of this legislation.

Based on the draft legislation, we have some suggestions that we believe would enhance your efforts. Our comments below focus on the following issues:

- Timing of program implementation
- Proposed measures and inclusion of additional measures
- Lack of performance standards and benchmarks
- Assuring reforms promote quality improvement, savings, and are budget neutral
- Measure harmonization and alignment across settings
- Alignment across other CMS demonstrations
- Public reporting
- Support for quality improvement

Timing of Implementation: The draft bill proposes initiating the program in FY 2012, with a five year phase-in. However, hospitals have ample experience with collecting data on these measures, having done so since 2004, and CMS has experience with auditing the data and giving feedback to hospitals. Given that the measures related to the conditions listed in the bill have been in use by hospitals via the Medicare RHQDAPU program, we believe implementation should start in 2010 and the program should be phased in over no more than two years by tying at least 1 percent (if not the whole 2 percent) of the payment incentive to performance in the first year.

Proposed Measures and Inclusion of Additional Measures: First, we are very pleased to see the inclusion of the HCAHPS survey as one of the chosen sets of measures. Both the National Partnership and the Pacific Business Group on Health are strong advocates for collection of data on patient engagement and patient experience. Including HCAHPS in this program is an important step and is also consistent with the goals put forth by the 28-member National Priorities Partnership (NPP).[1] Additionally, hospitals have experience using this survey so they will not need a transition period.

We also agree with the position that the program must focus on high-cost and high-utilization conditions. Regarding conditions/procedures that should be included – notably AMI, heart failure, pneumonia, and surgery – many of the measures in these areas have been used in the hospital setting for several years and hospitals have had ample time to understand the goals, practice collecting data, see their results publicly reported and work on quality improvement. In fact, some measures are being retired due to performance having topped out (e.g. pneumonia oxygenation assessment, and AMI-6 "Beta Blocker at Arrival"). Emphasis should be placed on improving hospital performance in areas of poor performance and high variation across hospitals. Not all of the proposed measures meet those criteria.

To maximize the positive impact of this legislation, we recommend focusing on the priority areas already identified by the NPP, which include patient safety and healthcare-acquired conditions, overuse, outcomes across multiple conditions, coordination of care, patient and family engagement, and palliative care. These priority areas represent opportunities for high impact improvement. Concrete steps for operationalizing the goals associated with the NPP priority areas would require CMS to: 1) collect a broad dashboard of performance indicators that assess patient safety, clinical effectiveness, patient-centeredness, efficiency, and equity; 2) emphasize areas where performance is low; 3) emphasize areas where variation is substantial, and 4) focus on areas relevant to Medicare beneficiaries. The measures should also be integrated with measures for providers in other Medicare settings (e.g., physicians in ambulatory setting, providers in post-acute care setting) to create alignment and a broader accountability framework that enables assessment of full episodes of care. This alignment and integration would create joint accountabilities among providers to ensure that the right care is being delivered. Measures also need to be closely aligned with the well-defined and articulated goals of the program.

We would be happy to help identify specific measures or sets of measures for your staff if that would be helpful. However, in some areas there are substantial gaps in the availability of measures. We therefore urge that the proposal include strong direction for CMS to

[1] See http://www.nationalprioritiespartnership.org/Home.aspx for more information on the National Priorities Partnership, including the 28 partner organizations and representatives and more information on the six priorities and goals.

financially support needed development and then have the authority to phase-in new measures as they are developed and validated.

In addition to broadening the range of measures used, we ask that you clarify the process for integrating new measures into the program. While the bill cites the RHQDAPU program as a guide for how measures will be added and reviewed, we believe the bill should clearly state how the new program will take advantage of the rapidly evolving field of measure development, endorsement, and review.

Lack of Minimum Performance Standards and Benchmarks: The bill specifically states that no minimum performance standards will be established for the purposes of determining hospital performance scores. It does not seem effective to implement a program that uses payment to incentivize quality without setting minimum performance standards and benchmarks. For the initial measures that will be used in the program, there is enough experience with their use to identify appropriate standards and benchmarks. CMS should be required to establish minimum thresholds of performance above which hospitals would be allowed to receive performance-based payments.

Assuring Reforms Promote Quality Improvement, Savings and are Budget Neutral
We question the purpose of a value-based purchasing program that does not seek to foster cost savings – or at a minimum maintain budget neutrality – as one of its ultimate goals. The program as described in this legislation would redistribute Medicare funding from hospitals that perform poorly to those that perform well, but it does not address the fundamental issue of waste in the system and the need to control costs. Given the financial solvency issues facing the Medicare system, this program offers CMS an opportunity to achieve savings as well as improvements in quality, as amply illustrated in both the Premier Hospital Quality Incentive Demonstration (HQID) and the CMS Physician Group Practice (PGP) demonstration. The HQID allows CMS to identify hospitals with the highest clinical quality performance for each of five clinical areas (AMI, CABG, heart failure, pneumonia, and hip and knee replacement) providing up to a 2 percent bonus of their Medicare payment, or up to 2 percent cut if they do not achieve performance improvements above the baseline. Average composite quality scores have improved significantly for all of the five areas since the program began. The PGP demonstration used a shared-savings model, whereby practices had to achieve savings and demonstrate quality performance, and a portion of the savings were retained by the practices and the other portion by CMS. This model should be applied in the hospital arena as well.

Additionally, CMS should consider taking funds that are not paid out to poorer performers and redeploying those resources into support structures to help low performers improve. The bill should consider payment mechanisms that share with hospitals the savings achieved through their more efficient delivery of higher quality care.

Measure Harmonization and Alignment Across Settings: We are actively engaged in promoting measure harmonization that enables the same measure to be used across settings and practitioners. We support the development of measures that can be used across settings, from the hospital, to the acute care environment, to the nursing home, and beyond. While this may be beyond the purview of this legislation, we believe it would be helpful to include language in the measurement section on the importance of cross-setting alignment and harmonization. Hospitals have noted that including doctors in the incentive payment structure is a key lever for driving physician behavior. Current silo-based

performance measurement and payment strategies will not create the aligned structures needed to drive behavior across multiple providers in various settings.

Alignment Across Other CMS Demonstrations: As referenced above, CMS is currently overseeing a number of efforts related to value and quality, including the Premier Hospital Quality Incentive Demonstration, the Physician Group Practice Demonstration, and the Physician Quality Reporting Initiative.[2] We strongly suggest that the bill not only refer to these programs, in order to provide a context for this new hospital VBP program, but affirmatively direct CMS to expand pilots, demonstrations and other methodologies that link the quality and costs of services across care settings. It would particularly be helpful to reference those programs that have shown some success in aligning incentives for both the hospital setting and across providers, such as the Acute Care Episodes demonstration, so as to include physicians practicing in hospitals. We also suggest adding a reference to the CMS Hospital VBP Plan, which was issued in November 2007. Many stakeholders provided thoughtful commentary on drafts of that report, which should be considered in developing the next version of this legislation. Your leadership in pointing out that hospital payments should facilitate more patient-centered care and reward coordination across settings in order to save money in avoided hospitalizations – is critically important.

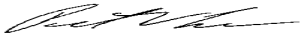
Public Reporting: We strongly urge you to incorporate some aspects of public reporting into the program. One way to do this would be to use the data collected through the VBP program to augment Hospital Compare. We also urge that the Hospital Compare website be redesigned to make it more user-friendly for consumers and purchasers.

Support for Quality Improvement: CMS should work to ensure that hospitals have the requisite systems support, training and tools to be successful in working to close the quality gap. In addition to financial incentives, providers may also need assistance in implementing new systems, which can be facilitated through information sharing around best practices and system redesign.

Again, we greatly appreciate your consideration of our comments and suggestions. As noted above, we have specific policy ideas for how to address a number of our comments, and we would be very pleased to work with your staff to develop potential solutions. If you have any questions, please contact either Peter V. Lee, Executive Director for National Health Policy at the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,

Peter



Peter V. Lee
Executive Director for
National Health Policy
Pacific Business Group on Health

Debra

Debra L. Ness
President
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[2] Additional relevant programs include the Nursing Home VBP Demonstration, the Home Health P4P Demonstration, ESRD Pay for Performance, and others.