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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives

"The Evolution of Quality in Medicare Part A"

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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 Ways and Means Committee hearing on the evolution of quality in Medicare Part A. We are pleased that the committee is interested in assessing the experience of hospitals in Medicare quality performance programs as it considers future payment reform efforts, including those intended for post-acute care providers. America's hospitals are strongly committed to transparency and the sharing of meaningful, accurate information on quality performance for hospitals and other providers. We also believe that well-designed pay-for-performance programs can support the field's ongoing transformation to value-based care.

Informed by more than a decade of experience with quality measurement and pay-for-performance in Medicare, we offer several recommendations to enhance existing hospital quality reporting and pay-for-performance programs so they more effectively drive the improvement in outcomes and health that all stakeholders – patients, policymakers and hospitals – want to see. Specifically:

- The measures used in Medicare quality reporting and payment programs should be streamlined to focus on the highest priority quality issues;

- The Hospital Readmissions Reduction Program (HRRP) should incorporate socioeconomic adjustment; and

- The Hospital-Acquired Conditions Reduction Program (HACRP) should be reformed to provide a fairer, more effective incentive to improve performance.

In addition, the AHA recommends changes to existing pay-for-performance legislation for post-acute care providers to achieve the appropriate balance between lower cost and better care.

MOVING TO MEASURES THAT MATTER

More than 10 years ago, hospitals began to voluntarily report key quality and safety data to the public. We started with 10 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 Congress then linked reporting on this voluntary effort to Medicare payment incentives. The Centers for Medicare & Medicaid Services (CMS) has rapidly expanded the number of measures hospitals are required to report. These data are displayed on the *Hospital Compare* website and used by CMS in many of its pay-for-performance programs for hospitals, including the Hospital Value-Based Purchasing (VBP) Program, HRRP and HACRP. 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.

Hospitals continue to strongly support transparency on quality. However, there are significant concerns that the explosion in measure reporting requirements is limiting the effectiveness of efforts to improve quality and causing confusion for the public. For example, in 2019 hospitals will have more than 90 measures in CMS hospital quality reporting and pay-for-performance programs – a fact that underscores the need to further streamline measures. Further, many of CMS's chosen measures are not related to issues that are the most pressing opportunities for patient improvement. These measures increase the burden of collecting data without adding commensurate value for patients. Compounding the dilemma, private payers and other regulatory bodies require the reporting of yet additional measures. As a result, hospitals are spending time interpreting measure requirements and gathering data that could otherwise be spent on improving care.

Many hospital leaders and clinicians also are frustrated by the multitude of hospital report cards, each of which uses different measures and methodologies for rating performance. Most recently, CMS introduced "star ratings" for acute care hospitals on *Hospital Compare*. **The AHA thanks the Congress for urging CMS to make improvements to hospital star ratings, and we will continue to urge CMS to adopt a less biased, more meaningful approach.** Hospital star ratings, like movie or restaurant ratings, give hospitals one to five stars based on performance on a select subset of measures. However, the star ratings raise far more questions than answers and add to a long list of conflicting rating and ranking systems. Hospitals are especially troubled that

the current rating scheme used by CMS unfairly disparage teaching hospitals and those serving higher numbers of the poor.

The AHA believes it is time to streamline and focus the measures used in national quality measurement programs on measures that truly matter to driving better outcomes and health for the patients we serve. To provide a starting point, the AHA has engaged hospital leaders in ongoing discussions on which measurement topics they believe are the highest priority for improving care. In 2013 and 2014, the association's governance committees discussed and prioritized measurement topics for use in assessing and incentivizing hospitals and health care systems. The AHA Board of Trustees then approved a list of 11 hospital quality performance priority topics that were identified through this work. In response to subsequent feedback, the AHA Board adopted minor updates to the list of priority measure topics in July 2016. We believe CMS should use these 11 priority areas to remove measures that no longer add value and to target areas that are currently unaddressed by CMS's reporting programs. The AHA's 11 measurement priority areas are listed below.

AHA Measurement Priority Areas

- Patient Safety Outcomes
  - Harm Rates
  - Infection Rates
  - Medication Errors
- Readmission Rates
- Risk Adjusted Mortality
- Effective Patient Transitions
- Diabetes Control
- Obesity
- Adherence to Guidelines for Commonly Overused Procedures
- End-of-Life Care According to Preferences
- Cost per Case or Episode of Care
- Behavioral Health
- Patient Experience of Care / Patient Reported Outcomes of Care

To better focus the debate over quality measures and ensure that national quality goals are being advanced through measurement, the AHA believes it is important to develop a set of strategic principles that establish the parameters for "measures that matter." As such, the AHA supports the following principles for measures to be used in public reporting and incentive programs:

1. Provider behavior must influence the outcome(s) being measured;
2. Measures must have strong evidence that their use will lead to better care and outcomes;

3. Measures should be used in programs only if they reveal meaningful differences in performance across providers, although some may be retained or re-introduced to reaffirm their importance and verify continued high levels of importance;
4. The measures should be administratively simple to collect and report, and to the greatest extent possible, be derived from electronic health records data;
5. Measures should seek to align the efforts of hospitals, physicians and others along the care continuum, and align with the data collection efforts of the other providers;
6. Measures should align across public and private payers to reduce unnecessary data collection and reporting efforts; and
7. Risk adjustment must be rigorous and account for all factors beyond the control of providers, including socioeconomic factors where appropriate. In addition, adjustment methodologies should be published and fully transparent.

Lastly, the AHA believes that patients' interests will be better served if hospital measurement priorities are aligned with those for other health care providers to ensure all parts of the system are working in coordinated fashion to drive improvement. For this reason, the AHA has urged CMS and other national public and private entities to use the recommendations of the National Academy of Medicine's (NAM) *Vital Signs* report. *Vital Signs* is a unifying framework that identifies 15 core measurement priorities common to all stakeholders in health — providers, public and private payers, public health agencies and patients. These 15 areas dovetail well with the AHA's list of 11 hospital performance priorities.

IMPROVING MEDICARE HOSPITAL PAY-FOR-PERFORMANCE

The Affordable Care Act (ACA) significantly raised the financial stakes of quality measurement by introducing three "pay-for-performance" programs tying payment to the level of quality performance. The VBP Program and HRRP began affecting hospital inpatient prospective payment system payments in fiscal year (FY) 2013, while the HACRP began in FY 2015. To date, hospitals have incurred nearly $1.9 billion of readmissions penalties and $737 million in HAC penalties.

The AHA generally supports the hospital VBP program because it rewards hospitals for both performance achievement and performance improvement over time. Importantly, this program is budget neutral, which means that hospitals do not lose payment unless their performance is subpar. However, we have significant concerns about the HRRP and HACRP and have urged several reforms to improve their fairness and effectiveness.

Readmission Penalties. The AHA has long urged that the HRRP incorporate socioeconomic adjustment to ensure that hospitals caring for our nation's most vulnerable patients are not disproportionately penalized. **We strongly support the bipartisan, bicameral Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (H.R. 1343/S. 688) and are pleased a version of this bill passed the House of Representative in June 2016.**

Since the HRRP's inception, hospitals caring for the poorest patients have been significantly more likely to receive penalties. In FY 2017, nearly 86 percent of hospitals in the highest quartile of disproportionate patient percentage (DPP) received a penalty, compared to 60 percent in the lowest DPP quartile (higher DPP quartiles indicate a poorer patient population). This is because the current HRRP fails to recognize that community factors outside the control of the hospital – such as the availability of primary care, mental health services, physical therapy, easy access to medications and appropriate food, and other rehabilitative services – significantly influence the likelihood of a patient's health improving after discharge from the hospital or whether a readmission may be necessary. These community issues are reflected in readily available data on socioeconomic status, such as Medicare claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. If H.R. 1343/S. 688 is passed, CMS would be required to use these data to adjust penalties, providing important relief.

The AHA also urges CMS to exclude from the HRRP readmissions unrelated to the initial reason for admission. Despite the fact that the ACA requires CMS to exclude unrelated readmissions, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission against the hospital.

Improving the HACRP. America's hospitals are deeply committed to reducing preventable patient harm. **However, the HACRP is poorly designed and imposes arbitrary, excessive penalties that disproportionately impact hospitals tending to care for the sickest patients.** The AHA will work with CMS, Congress and others to improve existing policy and promote alternatives to the HAC program that more effectively promote patient safety.

The HACRP has several critical flaws. First, the program's arbitrary design penalizes 25 percent of all hospitals each year, regardless of significant performance improvement, and it does not measure meaningful differences in quality. Indeed, the difference in HAC scores for penalized and non-penalized hospitals in FY 2015 is hundredths of a point. Second, data show that hospitals treating complex patients are disproportionally penalized, in part because the HACRP uses claims-based patient safety indicators (PSIs) that are unreliable and do not reflect important details of a patient's risk factors and course of care. We have urged CMS to remove PSIs gradually from the HACRP. Third, some small hospitals have too few patients to have data on the two infection measures used in this program. These hospitals are assessed only on the unreliable PSIs. Finally, the HAC measures overlap with the measures in the VBP Program, yet each program uses different performance periods. This can lead to excessive payment penalties and confusion about the true state of hospital performance. To provide short-term relief, the AHA recommends that the Administration use measures in either the VBP or the HAC program, but not in both.

MOVING PAY-FOR-PERFORMANCE INTO POST-ACUTE CARE

Given the widespread use of pay-for-performance in Medicare for hospitals and physicians, policymakers have begun to express an interest in adopting pay-for-performance programs for post-acute care providers. Last year, the House introduced, H.R. 3298, the Medicare Post-Acute

Care Value-Based Purchasing (PAC VBP) Act of 2015, which would repeal the FY 2018 market-basket update cap for post-acute care providers mandated by the Medicare Access and CHIP Reauthorization of 2015, and replace it with a PAC VBP program. **In concept, the AHA agrees with the potential for pay-for-performance to accelerate improvements in post-acute care. However, we urge a number of improvements to H.R. 3298, as we are concerned that the bill too narrowly focuses on reducing provider payment rather than promoting "value" – that is, the delivery of consistently high-quality care at a lower cost.**

The AHA urges Congress to reconsider the non-budget neutral design of H.R. 3298. The PAC VBP program would withhold a percentage of post-acute care provider payments. Individual providers could earn back some or all of the withheld funds – and potentially earn a bonus – based on their performance. However, the program is not budget neutral – only 50 to 70 percent of the withheld funds could be paid back to providers, with the rest being retained by Medicare as savings. The AHA does not support utilizing VBP to achieve reductions in the Medicare program; the PAC VBP program should be budget neutral.

Moreover, we urge that any PAC VBP effort use a combination of cost and quality measures, rather than focusing on cost alone. AHA members are deeply engaged in efforts to provide more accountable care that delivers greater value. The AHA believes pay-for-performance programs should include both cost *and* quality measures to ensure that the reward system encourages both high-quality care and lower costs. Those measures should be broader than just Medicare spending per beneficiary (MSPB) and a single quality measure (functional status); additional quality metrics should be included. Without a more balanced, budget-neutral approach that includes an assessment of quality, the PAC VBP program appears to function as a mechanism to cut provider payments in perpetuity, rather than primarily as a way to promote value.

Furthermore, the proposed PAC VBP scoring methodology would tie too much of an individual provider's performance to the actions of other providers that are beyond their control. The intent of the scoring methodology appears to be to encourage collaboration among providers. However, we believe there are more appropriate and effective ways to encourage collaboration, such as assessing costs during an episode of care or setting performance benchmarks for individual providers that partially reflect a geographic area. In addition, we note that any measures used in PAC VBP should be assessed for the impact of socioeconomic factors on performance; socioeconomic adjustment should be employed when needed.

Lastly, the AHA believes the PAC VBP's payment withhold should be in step with those of other Medicare VBP programs. Indeed, the hospital VBP program, the End-Stage Renal Disease Quality Improvement Program, and skilled-nursing facility VBP program all have maximum withholds of no more than 2.0 percent. Furthermore, post-acute care providers already face numerous regulatory and statutory payment reductions and restrictions in recent years – such as site-neutral payment for long-term care hospitals, the "60 percent rule" for inpatient rehabilitation facilities, and re-basing cuts for home health agencies, to name a few. Post-acute care providers also have 2.0 percent of their payments at risk for meeting extensive quality measure reporting requirements. The cumulative impact of these policies is making it significantly more challenging for these providers to serve their patients and communities.

CONCLUSION

Despite the significant challenges with existing quality measurement and pay-for-performance programs, hospitals are making important progress in improving care, as discussed in the AHA brief, "Zeroing in on the Triple Aim." By streamlining and focusing on "measures that matter," enhancing the fairness of pay-for-performance and aligning improvement across the care continuum, we believe our nation can greatly accelerate improvements in outcomes and health.