Consumer-Purchaser DISCLOSURE PROJECT Improving Health Care Quality through Public Reporting of Performance

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RE: Plan to Implement Medicare Hospital Value-Based Purchasing

Dear Ms. Phillips:

Thank for the opportunity to comment on the design questions posed in the Issues Paper on the Medicare Hospital Value-Based Purchasing Plan Development. The undersigned organizations applaud the leadership demonstrated by the Centers for Medicare & Medicaid Services (CMS) in advancing a reimbursement system that encourages the provision of high-quality, efficient, patient-centered care. Far too many of today's payments reward quantity, errors, rework and unnecessary care, rather than promoting better quality, coordination, greater efficiency and more effective delivery of care. In that context, the comments that follow are based on our common belief that the value-based purchasing elements described in the Issues Paper reflect one part of the more fundamental changes needed to reform Medicare's payment policies. As CMS moves forward with its efforts to make payments sensitive to performance, we urge that it:

- Differentially pay providers who deliver higher quality, evidence-based care more efficiently;
- Develop payments for care coordination that support the integration and delivery of services for those with chronic illnesses;
- Develop payments that support reengineering of care; and
- Structure payments that recognize efficient and effective care may reduce expenditures both within a single sector and between sectors (e.g., physician services may reduce expenditures in emergency rooms and hospital care).

While our input on the specific questions is articulated below, we first wanted to voice our support for the goals of the Medicare Value-Based Purchasing Program (VBP) and in particular the parameters of the VBP Program as outlined, namely that it will:

- Be budget neutral;
- Add measures quickly;
- Measure and differentially pay for performance in the outpatient setting; and
- Develop ongoing evaluation process to examine impact and monitor for unintended consequences.

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What follow are specific comments on the four sections of the Issues Paper: (1) measures, (2) data infrastructure and validation; (3) incentive structure; and (4) public reporting.

MEASURES

We affirm the need for measures and payment to support the provision of care that is high quality, patient-centered, efficient, and equitable (e.g., reducing disparities in health care). To that end, CMS should use NQF-endorsed measures for both public reporting and value-based payment. In order to address the full spectrum of care and the multiple dimensions of quality, we strongly support the inclusion of structure, process, outcome, patient-experience, and efficiency measures for both purposes. We applaud the efforts CMS has made to work collaboratively with the Hospital Quality Alliance (HQA) and to actively reach out to key stakeholders including the hospital, consumer, and purchaser communities. We also applaud CMS moving rapidly to develop and report measures of hospital outpatient settings and ambulatory surgery centers and believe that they should also be incorporated in value-based purchasing.

Criteria for Measurement Selection

We support using the criteria outlined in Table 1, however we suggest the following additions/clarifications to Table 1:

Importance

- Measures must be relevant to consumers and purchasers.
- Measures/conditions should be assessed for the number of patients affected and for the financial impact on individual patients and the health care system as a whole.

Scientific Acceptability

- Perfect science should not delay the availability of good and useful information. Measures must be scientifically sound and evidence-based, but unrealistically high tests of accuracy or precision should not prevent implementation of an otherwise valid measure.
- The measure may also be a proxy given appropriate evidence (e.g., volume in certain high risk procedures serves as a proxy for good outcomes).
- Where possible, outcome measures are preferred. New evidence[1] shows currently endorsed hospital process measures are only loosely linked to outcomes. Where there is evidence strongly linking process measures to patient outcomes, process measures may be appropriate. (We affirm that an adequate and specified risk-adjustment strategy is a critical requirement.)

Usability

- Differences in performance levels are meaningful. (It is important to note that statistical significance tests need to balance the risks of under-identifying or mis-identifying providers' performance. It is critical for consumers to have information that enables them to assess meaningful differences in performance.)
- Effective presentation and dissemination strategies exist or can be created.
- Methods for aggregating the measure with other, related measures (e.g. to create a composite measure) are defined or can easily be defined.

We suggest the following additions/clarifications to the criteria described in Table 2:

Controllable (change to "Ability to Influence")

[1] Werner, R.M., and E.T. Bradlow, "Relationship Between Medicare's Hospital Compare Performance Measures and Mortality Rates," *JAMA*, 296:22 (December 13, 1006), 2694-2702.

- Measures should be associated with practices that a provider can influence or impact. [This suggested language mirrors the AQA Parameters for Selecting Measures for Physician Performance v. 3, revised April 2006.]

Potential for Unintended Consequences

- While recognizing the VBP has the potential for unintended consequences, we expect that it's much more important result will be to more appropriately link reimbursement to performance and help promote continuous quality improvement. We also feel that it is important to recognize that virtually all types of current payments themselves have unintended and often perverse consequences.

Contribute to Comprehensiveness

We strongly support the criteria listed. In addition, we would suggest adding that:

- Measures should recognize that hospitals are part of a larger, inter-connected health care system and that all levels must be held accountable.
- Measures should address the entire population (especially for conditions or treatments that pertain to the Medicaid population), e.g., obstetrics, pediatric conditions, etc.

Additional Measure Development Urgently Needed

In order to address the full spectrum of care and the multiple dimensions of quality, more nationally endorsed standardized measures are urgently needed. The Federal Government should work with private funders to support the development and endorsement of a robust set of hospital performance measures. CMS and the Agency for Healthcare Research and Quality (AHRQ) should support the development of measures that assess: (1) clinical outcomes (safe, timely, and effective care); (2) efficiency[2] (prices and resource use over time); (3) equity (gender, race, ethnicity); and (4) patient-centeredness. We recommend the following actions:

- HHS, CMS, and/or AHRQ should provide substantial and ongoing funding to support development of consumer-relevant measures that fill existing gaps (especially clinical outcomes, efficiency, patient-centered/continuum of care, and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers' and purchasers' needs, the federal government should specifically support the rapid development of measures that are:
    - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound and evidence-based, but are not held to unrealistically high academic standards such that good and useful information is delayed.
    - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed are currently available in electronic form or can be collected with limited reporting burden.
    - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must be a significant factor in the development of measures.
    - Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.

[2] For additional information, see Pacific Business Group on Health, Hospital Cost Efficiency Measurement: Methodological Approaches, January 2005 (www.pbgh.org/news/pubs/documents/PBGHHospEfficiencyMeas_01-2006_22p.pdf) and the Leapfrog Group's Overview of Hospital Resource-Based Efficiency which can be accessed at https://leapfrog.medstat.com/insights/references/efficiency.htm

    - Address appropriateness of care. Measures are needed to assess whether or not the care provided to the patient was needed (e.g., measures of overuse of treatment of services should complement measures of underuse).
- HHS or CMS should provide core ongoing operating support for the National Quality Forum (NQF) to ensure an ongoing, independent consensus process reviews, endorses, and updates measures to enable the availability of comparative information and the reduction of provider reporting burden.

Incorporate Measures Rapidly
We urge CMS to add new measures rapidly, both to the Hospital Compare website and for inclusion in the VBP Program. CMS should consider enabling hospitals to submit data for posting on Hospital Compare prior to using the measure(s) for payment. We are concerned that if CMS fully retires a measures when performance has reached a theoretical or real maximum, that this high level of performance will not be sustained and "backsliding" will occur, though we recognize that there may be other sound reasons to retire a measure.

Composite Measures –Public Reporting and Payment
Composite measures show promise for **both** value-based payment and for public reporting and CMS should move rapidly to display composite scores on Hospital Compare. The development of composite scores is critical to help consumers integrate complex information into their decision making. Research, consumer testing and "real world" experience should be key factors in CMS's assessment of alternative methodologies (i.e., "appropriate care measures" versus the "opportunity model"). Options for constructing composites could include a total, overall score combining clinical quality, patient experience, and efficiency; a score on each of those three respective domains, and a composite by service line, such as diabetes, cardiac care, etc..

While composites would increase the transparency and meaningfulness of health care performance information, CMS should maintain the ability for consumers to "drill down" to a granular level of performance detail. The utility of the CMS Compare websites to consumers would also be dramatically improved if the presentation of information showed meaningful differences in provider performance (see additional comments in the Public Reporting section below).

CMS should also continue to allow private-sector organizations to have full access to provider performance information (numerator and denominator) from the Compare websites. Many plans rely heavily on the all-payer data to populate their provider selection tools and without access to granular performance data would impose additional reporting requirements on providers.

DATA INFRASTRUCTURE AND VALIDATION
We strongly encourage CMS to explore the following opportunities that would improve the efficiency of data flow, namely:

- CMS, Joint Commission, Performance Measurement System vendors, and hospitals should identify strategies to reduce or eliminate duplicative algorithm programming by multiple vendors through the use of common code. The current multi-vendor system needs to be assessed for inefficiencies given the planned expansion in measurement.
- CMS and Joint Commission should recognize a common strategy and process for validating measure results to reduce duplication of effort.

Note that the above strategies were also identified in a study commissioned by the Hospital Quality Alliance and performed by Booz Allen Hamilton.

Ensuring the accuracy and completeness of data is absolutely critical so that all stakeholders believe in the credibility of the information given its increasing relevance in the marketplace. As CMS continues to work to ensure the accuracy of the information posted on the Hospital Compare website, the methodology adopted should be fully transparent to allow all stakeholders to clearly assess hospital-level reliability. CMS should consider quantifying the marginal cost and benefits associated with data accuracy/completeness and the impact on the implementation timeline, so that representatives from the hospital, research, provider, purchaser, and consumer communities can better assess the tradeoffs.

While the Issues Paper did not solicit suggestions on how to improve billing or other administrative data sources, we wanted to call attention to recently published research[3] that outlines how claims data could be enhanced to enable a better understanding of patient acuity and more robust quality reporting. We would ask CMS to act on these research findings and require hospitals to submit claims data augmented with clinical data elements (e.g., additional laboratory values).

INCENTIVE STRUCTURE

Incentives should support the evolution of the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. Pay for performance as outlined in the Issues Paper is important, but would not result in the changes needed to foster a reimbursement system that:

- Encourages care coordination and supports the integration and delivery of services for those with chronic illnesses.
- Supports the re-engineering of care systems.
- Reduces health care disparities and encourages the provision of quality care for at-risk populations.

One way that even the current payment reforms could drive toward a health care system that accomplishes the above goals, is for a disproportionate share of incentives be made available for care delivery that promotes these goals (rather than having all types of care have the same potential rewards for "better" performance).

We concur with the Institute of Medicine's *Rewarding Provider Performance* report that recommends that incentives should be based on a combination of improvement and meeting performance thresholds. Indeed, many private sector incentive programs, operated by health plans and other organizations, such as The Leapfrog Group's "Hospital Rewards Program", reward both *top performers* and *performance improvers*. As Medicare moves to institutionalize performance-based payment, it should consider how to use baseline thresholds of performance and the potential of relative comparisons to encourage and foster all hospitals to make improvements appropriate to their current level of performance.

Because of the evidence that performance dramatically varies within hospitals, incentives should be available and calculated both at the service-line level (e.g., for specific clinical areas such as surgical infection rates) and hospital-wide (e.g., for H-CAHPS). Because of the potential for significant variation in performance across the country, CMS should consider using regional or state-level performance thresholds/cut-points as the initial basis for payment, though over time performance thresholds should be based on national standards.

[3] Pine M, Jordan H, Elixhauser A et al. Enhancement of Claims Data to Improve Risk Adjustment of Hospital Mortality, JAMA. 2007; 297:71-76.

The share of payment tied to performance should be substantial. We believe that initially the performance incentive for hospitals should be on the same order of magnitude as the level of incentive that rewards public reporting for the FY07 annual market basket update, which is 2% of total Medicare payments. Over time the overall proportion of CMS payments to hospitals that are directly linked to performance should grow significantly. CMS should set and revise the appropriate level using the information that continues to develop from its implementation of performance-based payments for all hospitals, its demonstration projects, and from private-sector efforts. As stated earlier, we also support performance incentives being budget neutral. Providing additional funding to finance performance incentives is an unrealistic option given the current economic and cost pressures faced by CMS.

PUBLIC REPORTING

All measures should be publicly reported, but CMS should ensure that they are made accessible and "evalauble" by the consumer. The scoring for public reporting should be divorced from the scoring of performance-based payments. The scoring of hospital performance and the display of information should be made, first and foremost, with consumer decision-making in mind; payment is intended to change provider behavior not the consumer's.

Further, we would urge that CMS work to publicly report hospital performance at the most granular level possible (i.e., at the individual hospital level versus aggregated across multiple campuses and at the condition or service-line level within hospital). Consumers need information at this level to inform their decisions. The utility of the Hospital Compare website to consumers would also be dramatically improved if the presentation of information showed **meaningful** differences in provider performance, instead of applying statistical tests that value more highly the risks of misclassification over the risks of not identifying highly likely differences in performance.

With regard to specific questions raised in the Issues Paper:

- Composites would increase the transparency and meaningfulness of health care performance information, but CMS should maintain the capacity for consumers to "drill down" to a granular level of performance detail.
- An indication of the uncertainty associated with performance – such as confidence intervals – should be available to those that have a particular level of interest in the details and operational specifics, but should not be the first level of information available to consumers.
- Performance scores should be suppressed for those hospitals without an adequate number of patients to generate scientifically valid results.
- Hospitals that are unwilling to report their data should be highlighted in public reporting.
- Trending performance is secondary to providing a consumer with the current picture of a hospital's performance, but would still be a useful aspect of the website. Again, this should be available as "drill down" information.

We would also call your attention to the Principles for Public Reporting of Health Care Information that were developed and endorsed by the members of the AQA (formerly the Ambulatory Care Quality Alliance) as an additional useful reference. These Principles can be found at: http://www.ambulatoryqualityalliance.org/files/ConsumerPrinciplesMay06.doc

One of the most constructive roles that CMS could play in providing decision-making tools to consumers is to continue to allow private-sector organizations to have full access to provider performance information (numerator and denominator) from the Compare websites. Many

plans rely heavily on the all-payer data to populate their provider selection tools and without access to granular performance data would impose additional reporting requirements on providers.

Finally, we encourage CMS to evaluate the impact of public reporting and value-based payment on quality, cost, and access. Thank you for the opportunity to comment on these proposed rules and for your leadership in this important area. If you have any questions, please contact either of the Disclosure Project's co-chairs, Peter Lee, CEO of the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

American Benefits Council
Consumers Union
Childbirth Connection
ERISA Industry Committee
General Motors
HealthCare21 Business Coalition
Midwest Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
National Retail Federation
New Jersey Healthcare Quality Institute
New York Business Group on Health
Pacific Business Group on Health
Service Employees International Union
St. Louis Area Business Health Coalition
The Leapfrog Group
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