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Testimony of the Greater New York Hospital Association
Before the Ways & Means Subcommittee on Health

Hearing on Incentivizing Quality Outcomes in Medicare Part A

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Good afternoon Subcommittee Chairman Tiberi and other distinguished members of the Committee. I am Elisabeth Wynn, Senior Vice President of Health Economics & Finance at the Greater New York Hospital Association (GNYHA). On behalf of our nearly 150 hospitals and health system members in New York, New Jersey, Connecticut and Rhode Island, GNYHA greatly appreciates the opportunity to testify about Medicare's hospital value-based purchasing (VBP) and other inpatient pay-for-performance (P4P) programs. We commend the Committee for taking up this very important topic, which is of great interest to our membership.

The P4P programs have appreciably advanced hospitals' focus on patient safety initiatives and outcomes—every hospital now has a dedicated effort to prevent infections, reduce readmissions, and improve patient satisfaction scores. While there is still much work to do, we are proud of our members' quality improvements results. GNYHA directly supports our members' efforts through innovative, hands-on quality improvement collaboratives such as our surgical site infection tracer program, which assesses hospital compliance with surgical safety checklists and protocols in the operating room and pre- and post-operative areas. We also have a joint initiative with our long-term care affiliate, the Continuing Care Leadership Coalition (CCLC), to improve hospital to nursing home transitions and reduce avoidable hospitalizations. In this effort, the focus is on standardizing communication protocols during the discharge and transfer process to ensure an effective and safe discharge to the most appropriate care setting.[1]

GNYHA also regularly analyzes and deconstructs the Centers for Medicare & Medicaid Services' (CMS) methods for the P4P programs, and we offer extensive technical comments and input to the agency through the annual rulemaking cycle. We also provide analytical tools for our members to enhance their understanding of the P4P programs and methods, and how their performance on individual measures translates into payment adjustments. For example, we recently replicated and evaluated CMS's Overall Hospital Quality Star Ratings. It is with this background and experience that we comment today.

Background

There are currently five P4P programs in the Medicare inpatient prospective payment system (IPPS). The term P4P means that certain IPPS payments are adjusted based on whether, in any fiscal year, a hospital meets the criteria for avoiding a payment cut or earning a high performance payment. The first of the five programs, the inpatient quality reporting program, was implemented under the Medicare Modernization

[1] Funded with support from the United Hospital Fund.

Act of 2003, while the other core P4P programs were enacted in the Affordable Care Act (ACA). Figure 1 provides a brief description of each program and the types of measures used.

Figure 1. Current Inpatient Hospital P4P Programs

Program	Program Description	Measures
Inpatient Quality Reporting (IQR) Program (FY 2005)	IQR requires hospitals to successfully report on prescribed measures or incur a 25% reduction to the applicable fiscal year market basket increase. Savings accrue to the Medicare program.	Hospitals report on roughly 60 different measures, including chart-abstracted measures, patient satisfaction survey data, hospital infections, and structural registry use.
Meaningful Use (MU) Incentive Program (FY 2010)	Hospitals must achieve milestones representing the meaningful use of electronic health records or face a 75% reduction in the applicable fiscal year market basket index increase.	Hospitals must demonstrate proficiency in EHR use across nine different objectives, including health information exchange, patient electronic access, public health reporting, and computerized order entry.

Value-Based Purchasing (VBP) (FY 2013)	VBP cuts each hospital's operating base payments by 2% and the "pool" is distributed to hospitals based on relative performance. Hospitals are scored on applicable measures, earning achievement and improvement points, and individual measure results are "rolled-up" into a VBP score. The program is budget neutral to the Medicare program.	Hospitals will be evaluated on 15 quality measures across four domains in FY 2017:
		• Patient and caregiver-centered experience of care (25%)
		• Safety (20%)
		• Clinical care (30%)
		  • Outcomes (25%)
		  • Process (5%)
		• Efficiency and cost reduction (25%)

Hospital Readmissions Reduction Program (HRRP) (FY 2013)	The readmissions program cuts hospital operating base payments by up to 3% for hospitals with risk-adjusted readmission rates above the national average. Savings accrue to the Medicare program.	Hospitals are evaluated based on their 30-day all-cause readmissions rates for the following conditions: • Acute myocardial infarction • Heart failure • Pneumonia • Chronic obstructive pulmonary disease • Total hip and knee arthroplasty • Coronary artery bypass graft surgery

Hospital-Acquired Condition (HAC) Reduction Program (FY 2015)	The HAC reduction program imposes a 1% cut on a hospital's total IPPS revenue (including indirect medical education [IME], disproportionate share hospital [DSH], uncompensated care, Sole Community/ Medicare Dependent Hospital, capital, and low volume payments) if the hospital's composite complication rate is in the worst quartile. Savings accrue to the Medicare program.	Hospitals are evaluated on performance across two domains:
		• Patient safety composite (25%)
		• Healthcare associated infections (75%)
		  • Central line-associated bloodstream infection (CLABSI)
		  • Catheter-associated urinary tract infection (CAUTI)
		  • Surgical site infection (SSI)

Estimated Fiscal Impact

Figure 2 presents the estimated impact of the five P4P programs on Federal fiscal year (FY) 2017 IPPS fee-for-service (FFS) payments for 3,218 affected IPPS hospitals.[2] The aggregate net loss to hospitals from the P4P programs—and savings to the Medicare program—is $930 million, of which the largest source is the readmissions/HRRP program (57%) and the second-largest source is the complications/HAC program (40%). The quality reporting and MU programs provide negligible savings to the Medicare program, but notable losses to affected hospitals.

Figure 2. Estimated Impact of P4P Programs on FY 2017 Payments for P4P-Eligible Hospitals

	# Hospitals w Gains or Losses	$ in Millions	Composition of Net Impact	% of Operating Base Payments
Payments before P4P adjustments:				
Total payments	3,218	$115,504	.	.
Operating base payments	3,218	$85,879	.	.
Impact of P4P adjustments:				
Quality reporting	117	($17)	2%	-0.02%
Meaningful use	169	($16)	2%	-0.02%
Readmissions	2,598	($529)	57%	-0.62%
Complications	743	($371)	40%	-0.43%
VBP gains	1,801	$172	-18%	0.20%
VBP losses	1,233	($172)	19%	-0.20%
Interaction	2,757	$3	0%	0.00%
Total	3,218	($930)	100%	-1.08%

Figure 2 also presents the impact of each P4P program as a percent of operating base payments. This denominator is used instead of total IPPS payments because it is the only component affected by all five P4P programs.[3] The aggregate net hospital loss of $930 million is roughly 1.1% of operating base payments, and the hospital level penalties generally top out at roughly 6%.

As shown in Figure 3, however, this impact varies by hospital cohort. (Hospitals eligible for at least one P4P program were assigned to mutually exclusive cohorts.[4]) Figure 3 orders the cohorts left to right, from the largest to the smallest P4P percentage loss. The cohort with the largest loss is major teaching hospitals (1.7%), followed by the four DSH cohorts *in descending order of their DSH burden*: high DSH (1.2%), medium-high DSH (1.1%), medium-low DSH (1.0%), and low DSH (0.6%). Sole community and Medicare-dependent hospitals have an even smaller loss than low DSH hospitals (0.5%), and low volume hospitals have the smallest loss (0.4%).

[2] GNYHA analysis based on payment parameters and hospital variables in the CMS FY 2017 IPPS Impact File.
[3] One of the complexities inherent in five separate P4P programs is that the penalties are applied to different elements of the IPPS rates. There are also interactions between the P4P adjustments and other policy adjustments such as indirect medical education (IME), disproportionate share hospital (DSH), and low-volume payments.
[4] Hospitals were assigned to cohorts in the following order: 1) SCH/MDH: hospitals receiving supplemental Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) payments, 2) Low Volume: hospitals receiving low volume payments that were not in the SCH/MDH cohort, 3) Major Teaching: teaching hospitals with a resident-to-bed ratio at or above the 75th percentile and not otherwise already assigned, and 4) all remaining hospitals, grouped to either the High, Medium High, Medium Low, or Low DSH cohorts based on the quartile ranking of their disproportionate patient percentages.

Figure 3. Estimated Impact of P4P Programs on Mutually Exclusive Hospital Cohorts

Percent of Operating Base Payments	All Hospitals	Major Teach	High DSH	Med-High DSH	Med-Low DSH	Low DSH	SCH/ MDH	Low Vol
Number of Hospitals:	3,218	259	542	541	541	542	420	373
Quality reporting	-0.02%	-0.03%	-0.02%	-0.01%	-0.02%	-0.01%	0.00%	-0.11%
Meaningful use	-0.02%	-0.03%	-0.03%	-0.01%	-0.01%	-0.01%	0.00%	-0.05%
Readmissions	-0.62%	-0.62%	-0.60%	-0.62%	-0.68%	-0.54%	-0.54%	-0.63%
Complications	-0.43%	-0.84%	-0.42%	-0.38%	-0.27%	-0.30%	-0.32%	-0.22%
VBP net gains/losses	0.00%	-0.17%	-0.11%	-0.06%	0.01%	0.22%	0.38%	0.57%
Interaction	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**-1.08%**	**-1.67%**	**-1.18%**	**-1.09%**	**-0.97%**	**-0.64%**	**-0.48%**	**-0.43%**

The VBP program mirrors Figure 3's cohort order. Major teaching, high DSH, and medium-high DSH hospitals all have net losses, while the other cohorts have net gains to help offset losses from the other P4P programs. Major teaching hospitals and most DSH hospitals also have above-average losses from the readmissions program, but major teaching hospitals have the largest loss because of disproportionate losses in the HAC reduction program.

Proposal for an Improved VBP Program

The P4P programs are only six years old, but much has been learned during this period. The key finding is that some of the technical methods used in the programs—including some methods embedded in the ACA—create systematic risk for certain types of hospitals. This means that certain types of hospitals have unfavorable results due to factors beyond their control. It is important for Congress to develop a second generation hospital inpatient P4P program that will better control for systematic risk and improve the program's validity and fairness.

Before suggesting ways to design a consolidated P4P program, we would like to review our concerns about the current programs.

Concerns about the Current P4P Programs

Complicated program structure. Inherent in the fact that there are five P4P programs is a complicated program structure that is not well aligned across programs. Each program has its own relatively sophisticated scoring methodology that embeds different policy preferences. For example, the VBP and HAC programs rank-order hospitals based on performance and confer points based on the decile of performance. This is a concern because it ignores the statistical significance of performance variation, so penalties are imposed for insignificant performance differences. In addition, only the VBP program confers points both on achievement and improvement, meaning that hospitals subject to penalties in the other programs have to improve more than other hospitals in order to reduce their financial impact, which is very difficult. Further, the HRRP and HAC program benchmarks are not set in advance, so hospitals do not know if improvements will translate into lower penalties. Taken together, this leaves the average hospital with little ability to understand how performance on a single quality measure impacts its performance-based payments and how to optimize its quality improvement efforts accordingly.

Measure duplication across programs. There is currently measure duplication both *within* programs, as evidenced by two different CLABSI measures within the HAC reduction program, and *across* programs, as evidenced by the CLABSI and CAUTI measures being included in both the HAC and VBP programs. In fact, 100% of the measures included in the HAC reduction program are also included in VBP. The presence of duplicate measures is not only burdensome, but can lead to confusion because of the different time periods, measure specifications, and scoring methods used across programs. Further, hospitals can be penalized twice for their performance on overlapping measures. The ACA acknowledged this problem, by expressly preventing measure duplication in the VBP and readmissions programs, but a similar provision was not included for the VBP and HAC programs. Although CMS could administratively remove the HAC measures from the VBP program, it has declined to do so.

Measure fatigue and complex reporting requirements. Hospitals suffer from measure fatigue and complex quality reporting requirements. These requirements are modified each year, with some measures removed and others added, but are never reduced and the administrative cost has grown apace. The burden of this activity diverts focus and resources from hospital quality improvement efforts. Unfortunately, there is also little measure alignment across payers, so hospitals must report a different measure set to private payers and state Medicaid programs.

Excessive penalties in certain programs. At the hospital level, the net fiscal impact across the five P4P programs ranges from negative 15.3% to positive 3.8% of operating base payments. Combined, these programs put hospitals at too great a financial risk. Also, because of design concerns discussed below, the readmission and HAC penalties are outsized relative to other measure domains such as mortality or efficiency. Over half of the penalties' aggregate net impact (57%) is from the readmissions program and 40% is from the HAC program. Combined, these programs cut hospitals by $900 million.

VBP program over weights patient satisfaction. The VBP program over weights the Patient-Centered and Caregiver Experience of Care domain (25% of the total score) based on hospitals' Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. This disadvantages safety net hospitals because they tend to score worse than non-safety net hospitals on patient satisfaction surveys. Safety net hospitals have lower overall margins, less staffing, and older capital plants with fewer amenities. This leads to inefficient facilities, fewer single patient rooms, more noise, and other conditions that make them less appealing. But the scores are not risk-adjusted for these factors, which disproportionately affect hospitals that principally rely on government payer revenue.

CMS does, however, risk-adjust for certain patient characteristics, systematically downgrading the scores of patients who are relatively less educated, in worse health, and for whom English is not their primary language because they tend to give higher scores than other patients. It is unfair to redistribute such a significant amount of funding to hospitals in more affluent communities without also risk-adjusting for facility factors that are generally beyond management's control.

Problems with the readmissions program. We have three main concerns with HRRP: 1) the 30-day readmission measure is not a measure of hospital quality but rather the availability of community-based care; 2) the lack of risk adjustment for socioeconomic, demographic, and environmental risk-factors of

patients; and 3) significant technical flaws in the construct of the readmissions penalty formula. Each of these problems is described below.

- ***Measures don't reflect hospital quality but rather availability of community-based care.*** CMS has adopted a 30-day all-cause readmission measure to evaluate hospital readmissions for six clinical conditions. The 30-day timeframe extends far beyond what the hospital itself can control. Rather than being a reflection of hospital quality, it measures patient and caregiver compliance with post-discharge instructions, availability of transportation, and access to appropriate community-based follow-up care. As a measure of *hospital* quality, a seven-day readmission measure would be far more appropriate because this would reflect problems with hospital care such as a surgical infection, HAC, poor discharge instructions, inappropriate early release and/or discharge destination.

- ***Lack of risk adjustment for Socioeconomic Status (SES).*** The challenges for hospitals treating patients with low SES status are well documented, as is the disproportionate impact of the readmissions penalties on safety net hospitals. Yet, CMS fails to risk-adjust the readmission rates for the sociodemographic patient factors that are beyond the providers' control, such as patient difficulty understanding discharge instructions because of poor health literacy or limited English proficiency, not having a regular source of primary or specialty care, or no family member to help with convalescence post-discharge.

  GNYHA commends the Committee for addressing this issue in House-passed H.R. 5273, *Helping Hospitals Improve their Care Act*. Among other improvements to the readmissions program, the legislation would require the Secretary of Health and Human Services (HHS) to evaluate hospitals against a peer group of similar hospitals, based on their proportion of dual-eligible patients. The Secretary could refine this approach in future years based on study results on SES factors required by the IMPACT Act. We strongly urge the Senate to adopt similar legislation.

- ***Flaws in the readmissions penalty calculation.*** GNYHA also has serious concerns about HRRP penalty calculation flaws that result in penalties that are far higher than the Medicare payments for the readmissions, and penalties that remain constant while industry readmission rates decrease. Over time, these characteristics will become significant deterrents for hospitals to take action and focus on improving readmission rates because they push hospitals to the 3% penalty cap.

  The HRRP statute includes a multiplier on hospital penalties for each condition such that the penalty is a multiple of the actual cost to the Medicare program for the readmissions. As shown in Figure 4, the multiplier varies by condition and is the reciprocal of the national average readmission rate, so the lower the average readmission rate the higher the multiplier. And as hospitals decrease readmission rates, the multipliers increase. The penalties for heart attack, for example, are six times the cost of the readmissions, but for hip and knee replacements, they are *over 20 times the cost of the readmissions*. This is an issue of great urgency because with each passing year, as more conditions are added to the HRRP, a legislative "fix" becomes more expensive. Further, if CMS were to adopt a 30-day hospital-wide readmission measure, as proposed in President Obama's budget, GNYHA estimates that the aggregate penalty would quadruple to over $2 billion because of the multiplier, and would be untenably higher without the 3% statutory penalty cap.

Figure 4. Effect of the HRRP Multiplier

HRRP Condition	National Readmission Rate*	Penalty Multiplier
Acute myocardial infarction (AMI)	16.8%	6.0
Heart failure (HF)	21.9%	4.6
Pneumonia (PN)	17.1%	5.8
Chronic obstructive pulmonary disease (COPD)	20.0%	5.0
Total hip arthroplasty (THA) and total knee arthroplasty (TKA)	4.6%	21.7
Coronary artery bypass graft (CABG)	14.4%	6.9

The current statute also fails to give the industry "credit" for the Medicare savings associated with reduced readmissions since HRRP's inception. Consequently, as the national readmission rate goes down, an average hospital's readmission penalty will remain roughly constant, essentially allowing the Medicare program to benefit twice (from reduced payments to hospitals for the readmissions that were averted, and the readmissions penalty). Congress must pass legislation to fix these problems with the readmissions penalty even if it chooses to not pursue a consolidated VBP program.

HAC program unfairly penalizes teaching hospitals. The penalty structure is problematic because one-quarter of the nation's hospitals are always subject to the penalty, regardless of whether hospitals are performing well on the measures or there are national improvements in complication rates. In addition, because hospitals are simply ranked, the statistical significance of performance differences is not considered. Further, because the reliability adjustment in the methodology essentially assigns rural and small community hospitals the national average performance, they rarely receive a penalty because they have little opportunity to be in the bottom quartile. This results in large, urban teaching hospitals being disproportionately penalized.

Unlike the other ACA P4P programs, the 1% penalty is applied to *all* inpatient payments. This results in an outsized penalty for affected hospitals. Therefore, as a percentage of base operating payments as opposed to total payments, the penalty ranges from 1.1% to over 11%, with 40 hospitals experiencing a cut of 2% or more.

Little relationship between P4P penalties and Star ratings. We regressed the dollar value of the penalties under the P4P programs with the recently released CMS Overall Hospital Quality Star Ratings, and found an R^2 of only 28%, meaning that the Star scores—the public indicator of hospital quality—do not effectively predict hospital P4P losses. While we have serious concerns about some design features of the Star ratings, namely that they give too much weight to the inadequately risk-adjusted patient satisfaction and readmissions measures, we are also concerned that this sends mixed-messages about Medicare's view of an individual hospital's quality performance.

Concepts for an Updated Performance-Based Payment Program for Hospital Inpatient Services

HHS issued its *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program* in November 2007. While that nine-year-old plan continues as the structure of the VBP program today, two recent events have advanced the thinking about performance-based payment: consolidation of the quality reporting, MU, and value modifier programs in the physician Merit-Based Incentive Payment System (MIPS), and the use of latent variable modeling in the Star rating system.

We like the streamlined effect of designating quality reporting and MU as domains of a single performance-based payment system, and we appreciate the sophistication and elegance of latent variable modeling to derive domain scores, which the Star rating system calls standardized group scores. We therefore recommend consideration of an updated hospital VBP program that adds together payment adjustments for quality reporting, MU, and performance in order to derive a single VBP adjustment to operating base payments. If the performance component of the new VBP adjustment replaced the current VBP, readmissions reduction, and HAC reduction programs, that would obviate the need to make technical improvements to those programs, provide an opportunity to use latent variable modeling to derive domain scores, and rebalance the impact of each domain on the hospitals' aggregate P4P adjustment, which today is overwhelmed by the readmissions and HAC penalties.

In fact, we strongly urge Congress and the Administration to eliminate the 30-day readmission domain from both VBP and the Star rating system because, as noted earlier, 30-day readmissions are not an appropriate measure of inpatient performance. Instead, we recommend developing seven-day readmission measures that could be classified as complications. Alternatively, the 30-day readmission domain could receive the lowest weighting in a total performance score (VBP) or hospital summary score (Star ratings).

We further recommend aligning the domains in the VBP and Star rating programs and rethinking the domain weights in both programs. Figure 5 shows the current domain weights in VBP and the Star rating system. If a new VBP program replaced the current VBP, readmissions reduction, and HAC reduction programs, as offered for consideration, we assume CMS would add readmissions as a domain in VBP and weight it equally with the other domains.

Figure 5. Domains and Domain Weights in the VBP and Star Rating Programs

	VBP			Star Rating System	
Generic Domain	Domain	FY 2019	If No HRRP	Group	Weight
Mortality	Clinical Care	25%	20%	Mortality	22%
Complications	Safety	25%	20%	Safety	22%
Evidence-based medicine				Effectiveness and timeliness of care	8%
Patient experience	Person and Community Engagement	25%	20%	Patient experience	22%
Efficiency	Efficiency and Cost Reduction	25%	20%	Imaging efficiency	4%
Readmissions	Readmissions		20%	Readmissions	22%
Total	.	100%	100%	.	100%

There are two principal differences between the programs. First, CMS is phasing evidence-based measures out of VBP, but includes them in the Star rating system. Second, CMS defines the VBP efficiency domain as measures of Medicare Spending per Beneficiary, but declined to use those measures in the Star rating system, saying it was unclear whether high or low standardized spending was more favorable. These conflicts should be resolved, especially regarding the efficiency domain because standardized spending per beneficiary is the cornerstone of CMS's Alternative Payment Models (APM) and its new mandatory bundled payment programs.

In addition, and in our view more importantly, we strongly urge policymakers to reweight the domains to align better with patient priorities and to lessen the effect of systematic risk (bias) in some of the measures. When being admitted to the hospital, a patient's top priority is no doubt survival and avoiding a medical complication, so we would give the highest weight to mortality, then complications, then evidence-based medicine, then patient experience, which includes communication and discharge planning. We assume the efficiency domain will eventually migrate to APMs and bundled payments, but would give it a low weight in the meantime. Again, we would eliminate the 30-day readmissions domain and replace it with seven-day readmissions measures in the complications domain.

Finally, if an updated VBP program replaces the five disparate programs, current Medicare program savings from the quality reporting, MU, readmission reduction, and HAC reduction programs can be: 1) eliminated (ideally), 2) converted into a permanent adjustment to the operating Federal rate so the VBP program can continue to be budget neutral, or 3) built into the VBP program as a fixed percentage of FFS base operating payments. If the third option is used, the new VBP program would both generate the requisite program savings and finance a high performance fund.

As Congress considers these issues, we also encourage it to adopt similar performance-based incentives in the other provider sectors using the lessons learned from the hospital P4P programs so that the financial incentives to improve quality and efficiency are aligned across sectors. This is especially important as providers work collaboratively to implement APMs for bundled payments or for the total cost of care in the case of accountable care organizations. Successful adoption of these models may be the only viable option for hospitals with a high Medicare and Medicaid payer mix to financially sustain their operations.

Conclusion

Thank you for the opportunity to testify. GNYHA encourages the Committee to consider these issues as it pursues its agenda to improve Medicare performance-based payments this fall. We believe that if adopted, the recommendations would improve the quality, efficiency, and fairness of the Medicare program. Even if the Committee does not put forth a comprehensive update of the current P4P programs, we hope it will at least address our technical and policy concerns about the readmissions program.