March 29, 2016

The Honorable Pat Tiberi
Chair
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1106 Longworth House Office Building
Washington, DC 20515

Re: Public Comment on Ways and Means Subcommittee on Health Hearing "Preserving and Strengthening Medicare."

Dear Chairman Tiberi & Ranking Member McDermott:

On behalf of the Healthcare Quality Coalition (HQC), we write to provide comments on the Ways and Means Subcommittee hearing "Preserving and Strengthening Medicare." We were very pleased to hear committee members and panelists supporting healthcare delivery that is value-based. The HQC echoes this strongly with our support of the development of robust value-based payment initiatives. Our members believe properly structured incentives to provide high value care (e.g. high quality, low cost care) will result in better care for patients at a lower cost for payers.

The HQC is comprised of hospitals, physicians, health systems, and associations committed to value-based healthcare. Combined, our members have more than 18,000 licensed hospital beds, more than 20,000 physicians, and have greater than 220,000 employees across the country. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care.

We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of

payment systems that reward value and we are pleased to provide testimony from a physician and hospital perspective on public policy that can help maintain a sustainable Medicare program.

Movement to Value Key for Long-term Medicare Viability

Medicare's predominantly fee-for-service (FFS) payment system, which rewards quantity over quality, is now widely acknowledged to be fragmented, inefficient, and financially unsustainable. The FFS system pays physicians based on the services they furnish and offers no incentives to coordinate care. The result is a system of fragmented care. FFS payments also create a financial incentive to promote volume over value, encouraging overutilization and discouraging low-cost, high-value services. Given the rising cost of health care and the resultant threat to the nation's long-term economic security, a payment system that supports an inefficient delivery system is not only undesirable but also unsustainable.

The HQC believes that Medicare should pay for value in the health care system. As a starting point, the HQC has supported and focused on programs that make modifications to the FFS scheme, such as the Physician Value-based Payment Modifier and Hospital Value-based Purchasing. These payment adjustments, however, are built on the FFS chassis, and the fundamental incorrect incentives of FFS remain the predominant payer source in the Medicare system. Just recently, Health and Human Services announced that 30% of medical service reimbursement in Medicare is now linked to various forms of non fee-for-service payment. The HQC believes this is a good step.

The HQC expressed support for the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) last year. The enactment of this bill was historic in that it not only eliminated the antiquated Medicare Part B Sustainable Growth Rate, but also consolidated existing physician performance initiatives and advanced value-based payment. We commend the efforts of the Ways and Means Committee to craft and advance bi-partisan, bi-cameral legislation to reform Medicare Part B service reimbursement. We ask the committee to continue their work on evaluating the implementation of MACRA, and be amenable to changes that may be necessary to ensure program success, accelerate the process towards value-based care, and reward high performing physicians.

Reform and Advance Value-based Policy in Medicare for Hospitals

Last year, the enactment of MACRA was a major step forward in reforming Medicare Part B payment. But advancing public policy cannot stop or even slowdown. To continue driving forward value-based policy, we ask the Ways and Means Committee to collaborate and develop bi-partisan legislation that would consolidate and reform performance and value-based payment for hospitals. We have long believed, to the extent feasible, that Medicare Part A and B should include comparative value-based reimbursement policy. To that end, we offer the following key points of emphasis for devising an improved Medicare value-based payment for hospitals that resembles the concepts of MACRA. Specifically, we ask the committee to:

- Consolidate and reform existing penalty-only programs into an improved Hospital Value-Based Purchasing Program, offering incentives and rewards for high performance

- Improve efficiency as a unit of *value* by modifying the improved Hospital Value-Based Purchasing program to weigh measures of cost and quality equally
- Advance value-based care by increasing the amount of payment tied to hospital performance
- Eliminate overlap with quality measures between separate hospital programs and improve the consistency of risk-adjustment and benchmarking
- Provide opportunities for developing and expanding hospital Alternative Payment Models

Step 1: Reform existing Medicare Hospital Penalty Programs

The HQC supports comprehensive value-based payment policies that integrate risk and offer rewards to hospitals that lead in improving patient experience, outcomes, and reducing the cost of care. We strongly believe properly structured payment reforms have an opportunity to significantly reduce the cost of care. However, performance-based programs that only assess penalties fall short of comprehensive value-based models. Reforming existing penalty programs to incent value by consolidating into a single Hospital Value-Based Purchasing program would align incentives, reduce duplication, and increase overall impact of the independent programs.

In the Hospital Readmissions Reduction (HRR) program, hospitals are compared to average performance of hospitals with similar patient case mix. In FY 2015, over 75% of eligible hospitals in the nation were subject to some level of readmissions penalty (maximum -3%), totaling over $420 million despite drops in national readmission rates.[1] [2] Meanwhile, the Hospital-Acquired Conditions (HAC) Reduction program assesses a 1% penalty for hospitals with the highest quartile rates of infections, injuries, and illnesses. Even though there has been a 17% national reduction in HACs[3] from 2010-2013, as designed, the HAC Reduction program will penalize 25% of hospitals every year, regardless of improvement. Further, like the Hospital Readmissions Reduction initiative, the HAC program is penalty-only.

While the HRR and HAC initiatives are designed to improve quality and reduce unnecessary spending, both are penalty-only programs, and do not provide positive incentives for high-quality, cost-effective care. Furthermore, as structured, the programs base performance on national averages, meaning hospitals may continue to be penalized even if they improve their readmission, infection, or safety rates. Finally, some measures are used in multiple programs, such as infection measures which result in overlap. Reforming the penalty-only structure of the program and consolidating into the Hospital Value-Based Purchasing program provides better incentives and eliminates the overlap and duplication of quality measures.

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[1]Sabriya Rice, "Most hospitals face 30-day readmissions penalty in fiscal 2016," *Modern Healthcare,* August 3, 2015, http://www.modernhealthcare.com/article/20150803/NEWS/150809981

[2] Jordan Rau, "Half Of Nation's Hospitals Fail Again To Escape Medicare's Readmission Penalties," *Kaiser Health News,* August 3, 2015 http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicares-readmission-penalties/

[3]Agency for Healthcare Research and Quality, *2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013,* AHRQ Publication No. 16-0006-EF (Rockville, MD, 2015), http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacrate2013.pdf

Step 2: Improve the Hospital Value-Based Purchasing (VBP) Program

The HQC supports the goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement.[4] Overall, the HQC believes hospital VBP is moving in a positive direction by emphasizing patient outcomes, assessing payment adjustments by actual performance, and maintaining the current weighting of efficiency and cost reduction metrics.

However, the current statutory structure of the program is ineffective in driving meaningful reform. The incentive amounts are small, payment differentiation is minimal, and is not sufficient to drive meaningful changes in hospital care.[5,6] The current 2% statutory cap on incentives will not sufficiently motivate hospitals to strive toward value-based care delivery. Removing the ceiling will link more payment to value and drive quality improvement forward.

In addition to removing the statutory cap on Hospital VBP, the HQC continues to support value as an equal reflection of cost and quality. Currently, the VBP program includes efficiency and cost reduction measures weighted at 25%. To further improve the program, we recommend the following steps: 1) Develop and implement a plan to increase the weight of efficiency and cost reduction domain to 50%; and 2) Incorporate additional risk-adjusted measures of efficiency in addition to the current Medicare Spending Per Beneficiary (MSPB) metric.

Step 3: Develop and expand voluntary hospital Alternative Payment Models

There are currently an array of programs and initiatives aimed at reducing cost and improving quality. Although the Medicare Accountable Care Organization (ACO) program has demonstrated mixed results,[7] experience from providers and hospitals participating as an ACO and other innovative models are integral for developing improved payment policy. In addition, as noted, MACRA was a milestone in Medicare physician payment policy by driving value-based care through existing programs and new payment models. Improved hospital inpatient and outpatient payment policy should take a similar approach, providing statutory authority for encouraging and incentivizing hospitals to undertake new models of care with opportunities for improved integration with clinical services.

In providing opportunities for future hospital inpatient and outpatient alternative payment models to flourish, we ask lawmakers to follow these guiding principles:

- Hospitals should have the opportunity to take on risk—rewarding quality and efficiency.
- Incentivize coordinated care and build on existing initiatives and infrastructure.

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[4] Daniel Blumenthal and Anupam B. Jena, "Hospital value-based purchasing," *Journal of Hospital Medicine* 8, no. 5 (2013): 271, doi:10.1002/jhm.2045

[5] Rachel M. Werner and R. Adams Dudley, "Medicare's new hospital value-based purchasing program is likely to have only a small impact on hospital payments," *Health Affairs* 31, no. 9 (2012): 1932, doi:10.1377/hlthaff.2011.0990

[6] U.S. Government Accountability Office, *Hospital Value-Based Purchasing: Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality of Care Trends,* GAO-16-9 (Washington, DC, 2015), http://www.gao.gov/assets/680/672899.pdf

[7] David Muhlestein, "Medicare ACO's: Mixed initial results and cautious optimism," *Health Affairs Blog,* February 4, 2014, http://healthaffairs.org/blog/2014/02/04/medicare-acos-mixed-initial-results-and-cautious-optimism/

- Capitated payment should be a core component of an alternative payment model.
- Risk adjustment and benchmarking should be meaningful and consistent across payment models.
- Flexibility and proper tools are essential to improve quality and reduce cost, including provider and hospital networks.
- Beneficiaries should be engaged in delivery system reform, such as patient involvement and understanding their stake in achieving value-based outcomes.

Conclusion

The HQC appreciates the opportunity to provide comments and ideas for ensuring a sustainable Medicare program. We believe the long-term viability lies in crafting reimbursement for services provided to Medicare beneficiaries that reflect robust value-based policy with measures of cost and quality. We look forward to being an active partner with the committee in moving value forward. Please feel free to contact us with any questions.

Sincerely,

The Healthcare Quality Coalition

The Healthcare Quality Coalition represents healthcare providers throughout the nation dedicated to the concept of value-based care. In short, we believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. The HQC is committed to developing value-based payment initiatives in a way that encourages fair payment to providers delivering high value care to the patients they serve. www.qualitycoalition.net