



November 22, 2010

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Dear Dr. Berwick:

As the Centers for Medicare & Medicaid Services (CMS) prepares its proposed rule to implement the hospital value-based purchasing (VBP) program, as required by Section 3001 of the *Patient Protection and Affordable Care Act of 2010 (ACA)*, we would like to take this opportunity to comment on several aspects of the program. America's hospitals are committed to improving the quality and safety of the care provided every day and welcome the opportunity to tie quality measurement to performance-based payments in a VBP program. We look forward to collaborating with CMS on all aspects of VBP, both now and in the future. To that end, we offer CMS a number of suggestions for how to structure the VBP program in a consistent and transparent manner that will accurately assess hospital performance and equitably distribute VBP payments, in order to achieve our shared goal of improved quality and patient outcomes. Our comments focus on the quality measures to be selected, calculation of the performance scores, minimum numbers of cases and measures for participation, distribution of the incentive payments, and other implementation issues.

OVERALL IMPLEMENTATION CONSIDERATIONS

We ask CMS to clarify the relationship between the VBP program and the current hospital inpatient quality reporting program. There has been some confusion in how CMS interpreted the ACA in the FY 2011 inpatient prospective payment system (PPS) rule. Regardless, we believe

that the continued reporting of quality measures on *Hospital Compare* is important for public reporting purposes, even if not all measures are incorporated into the VBP program. When CMS publishes the proposed rule for the VBP program, we encourage the agency to seek comment on a transition process whereby new measures may initially be reported and then later assessed for incorporation into the VBP program. We also encourage CMS to propose a process for continuing some voluntary reporting capabilities, such as for the children's asthma care measures.

We also ask CMS to articulate how the agency expects in the future to integrate the measures used for the VBP program with the clinical quality measures used to demonstrate meaningful use under the Medicare electronic health records (EHR) incentives program. It is unclear whether CMS has a roadmap for getting to one core set of quality measures that reaches across the agency's various hospital reporting programs. For example, the emergency department throughput measures that were finalized for incorporation into the hospital quality inpatient reporting program in fiscal year (FY) 2014 are specified for manual data abstraction, yet the same measures are specified for collection through EHRs for stage one of meaningful use.

QUALITY MEASURES

The foundation of the hospital VBP program will be the measures that CMS selects to assess hospital performance. Hospitals currently are reporting on a broad number of measures through the hospital inpatient quality reporting program, formerly known as the Reporting Hospital Quality Data for Annual Payment Update Program. Many of these measures would add value to and are appropriate for public reporting, but not all are appropriate candidates for the VBP program. In selecting measures for the VBP program, CMS should use measures that fall under the National Quality Strategy, are endorsed by the National Quality Forum (NQF) and recommended by multi-stakeholder groups, such as the Hospital Quality Alliance (HQA) or the future Measure Applications Partnership. We also suggest that CMS look to a framework for evaluating quality measures that was put forward recently by The Joint Commission. According to The Joint Commission, "accountability measures" are those measures that maximize health benefits to patients because they fulfill four criteria:

- 1) The measure is based on solid research that shows that following a particular care process leads to improved patient outcomes;
- 2) The measure accurately assesses whether evidence-based care has been delivered;
- 3) The measure addresses a process of care that is close in proximity to the desired patient outcome; and
- 4) Unintended adverse consequences associated with the measure are minimal to none.

It has been suggested that those measures with universally high scores among hospitals, referred to as "topped out" measures, should not be included in a VBP program. We disagree with the notion that measures with consistently high scores are inherently not useful in evaluating hospital performance. Rather, the selection of measures for the VBP program should be based on the measures' ability to improve patient care and patient outcomes.

Outcomes Measures. While most of the measures used for the hospital quality inpatient reporting program are process measures, there are several outcomes measures currently reported on *Hospital Compare* assessing 30-day mortality and readmissions for heart attack, heart failure and pneumonia patients. Within the next several years, measures assessing rates of central line-associated blood stream infections (CLABSI) and surgical site infections (SSI) will be reported by hospitals and posted on *Hospital Compare*. The hospital field is supportive of developing outcomes measures that can accurately assess hospitals' ability to achieve positive outcomes for their patients.

With regards to selecting measures for the VBP program, by law, CMS cannot include the readmissions measures in the hospital VBP program. Thus, the only outcomes measures available for the first year of the VBP program are the mortality measures. Since reporting on the mortality measures has begun, there has been discussion in the quality measurement community, including researchers, clinicians, providers and consumer groups, as to the ability of the mortality measures to accurately assess differences in patient outcomes among hospitals. Providers have ongoing concerns that the risk-adjustment methodology in the current mortality measures is not robust enough to accurately capture differences among hospitals' patient populations. In particular, the measure does not adjust for or exclude patients who are very near the end of life or who have expressed a preference for not receiving life-sustaining treatment. Consumers have expressed concerns about the measure display because *Hospital Compare* groups hospitals into only three performance buckets, and most hospitals achieve a mortality rate that is no different from the average, and, therefore, most hospitals look the same.

We believe that the continued debate on the adequacy of the risk adjustment as well as the scientific and quality reporting acceptability of the mortality measures, as they currently are specified, should give CMS pause when considering whether or not to include them in the VBP program. We encourage CMS to continue to develop outcome measures and refine the methodology of the mortality measures.

Healthcare-associated Infections. CMS is statutorily mandated to include measures in the hospital VBP program that assess healthcare-associated infections, as measured by the prevention metrics and targets established in the Action Plan to Prevent Healthcare-Associated Infections of the Department of Health and Human Services. The hospital field is supportive of reporting infection rate measures and including such measures in the VBP program. Because data collection will not begin on the CLABSI measure until 2011 and on the SSI measure until 2012, CMS will not be able to use these measures in the initial year of the VBP program. Thus, the hospital field believes that the surgical care measures, which are included in both the existing surgical care measures set and the Action Plan, should be used as the healthcare-associated infection measures in the early years of the VBP program. However, hospital performance on these measures should be counted only once in calculating hospitals' VBP performance scores, even though the measures fulfill two different VBP measure categories. The hospital field believes that the hospital-acquired condition (HAC) measures that were finalized in the FY 2011 inpatient prospective payment system (PPS) rule should never be used in the hospital VBP program in their current format. These measures are derived from billing data and capture information only on a subset of the hospital's patients. They are neither endorsed by the NQF

nor adopted by the HQA and, further, have never been vetted by the scientific community or field-tested among hospitals. In the future, we encourage CMS to identify additional infection-related measures that are derived from patient medical records or electronic health record systems and can be collected through a standardized and validated process.

CALCULATING PERFORMANCE SCORES

One of the critical decisions that CMS will need to make in designing the VBP program is the weight to give to each individual measure or category of measures in determining a hospital's overall VBP performance score. We suggest that CMS explore different weighting methodologies and present several options for public comment in the VBP proposed rule. One of the methods CMS should explore is weighting scores by "opportunities to provide care," where a hospital's overall denominator would be the sum of every opportunity it has to provide the right care. This option naturally weights each hospital's score by its own patient mix. In contrast, if CMS proposes to group measures into the broad categories of process measures, patient experiences and outcomes measures, these categories should not be weighted equally.

MINIMUM NUMBER OF CASES AND MEASURES FOR PARTICIPATION

CMS will need to determine the minimum number of patient cases that a hospital must have for each measure to participate in the VBP program. While hospitals' performance scores traditionally have been reported on *Hospital Compare* if they had at least 25 patient cases per quarter, little empirical work has been done to evaluate whether this is a statistically appropriate threshold. As directed by the ACA, CMS must conduct an analysis of what minimum thresholds are appropriate. We urge CMS to publicly release the results of those studies no later than the date of publication of the proposed rule, so that the studies may inform comment on the rule. A hospital's performance on these quality measures will determine the payment it receives. It is inappropriate for hospitals to be penalized because of instability in their data caused by having a small number of cases or measures. Likewise, data instability could cause smaller hospitals to see their performance swing wildly in a positive or negative direction from one year to the next.

In addition to determining the minimum number of patient cases per measure, CMS will need to set a minimum number of measures for which hospitals must have data for participation in the VBP program. Depending on how CMS chooses to construct the overall performance score, the agency also may need to determine a minimum number of measure domains (*e.g.*, heart attack care or process measures) for participation. It seems logical to exclude hospitals whose only measures are the patient experiences of care measures. It also seems reasonable to expect hospitals to have scores for at least half of the VBP measures in order to participate in the program. However, we urge CMS to offer several options for a minimum measure threshold in the proposed rule so that the agency can solicit public opinion on this topic.

The decision as to whether or not a facility has enough data to participate in the VBP program will have a large financial impact on the hospital and its ability to plan for any future investments in its quality improvement infrastructure. We urge CMS to alert an affected hospital as soon as possible if it will not meet the minimum participation threshold for a VBP program year. We also encourage CMS to think broadly about which hospitals to include in the mandated demonstration program for hospitals excluded from VBP because they have an insufficient

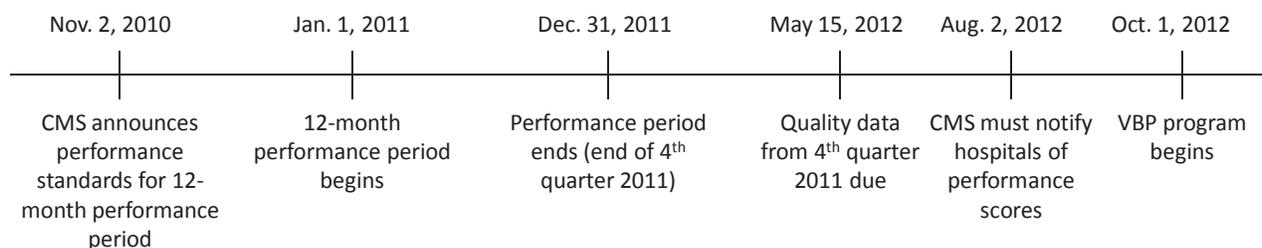
number of measures and cases. Because there are several levels in the assessment process – at the patient case, measure and domain level – at which a hospital may not have enough data for participation in the VBP program, there is the possibility that hospitals not usually considered to be “small” hospitals may find themselves excluded from the VBP program. We encourage CMS to set broad parameters that would allow a wide variety of hospitals to participate in the demonstration.

TIMING OF VBP PROGRAM IMPLEMENTATION

The ACA sets out certain parameters regarding the timing of VBP program implementation. First, the VBP program begins on October 1, 2012. Second, CMS must notify hospitals of the performance period scores that will be used to determine their VBP incentive payment at least 60 days before the VBP program begins, or by August 2, 2012. Finally, CMS must announce the standards that will be used to assess hospital performance at least 60 days before the performance period begins.

CMS has the flexibility to define both the length and timing of the baseline and performance periods, within the ACA parameters. While the hospital field believes that longer periods of measurement more accurately portray hospital quality, comparability between the two periods is critical and should be given priority. Specifically, in order for CMS to notify hospitals of their performance period scores by August 2, 2012, the most recent quality data the agency would be able to use are the data that are due to the warehouse May 15, 2012, which are data on hospitals’ performance in the 4th quarter of 2011 (see fig. 1). Thus, if the performance period were to be 12 months in length, it would have to begin January 1, 2011. However, CMS also is required to announce the standards that will be used to assess hospital performance at least 60 days before the performance period begins. If the performance period were to begin on January 1, 2011, CMS would have had to announce performance standards by November 2, 2010. Thus, it will not be possible for CMS to have a 12-month performance period for the first year of the VBP program.

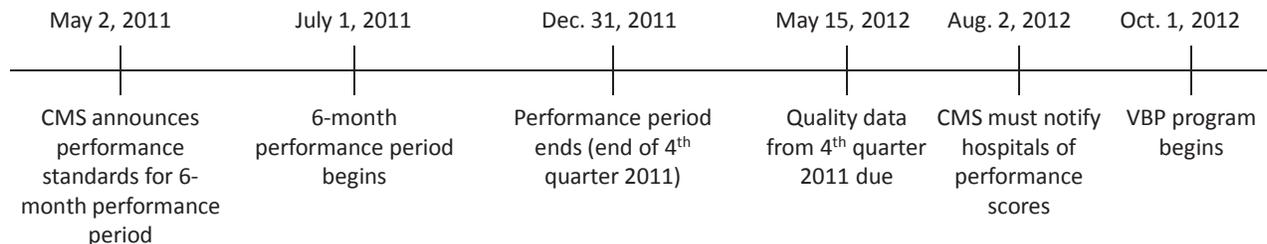
Figure 1: Fiscal Year 2013 VBP Timeline with 12-month Performance Period



In the first year of the VBP program, the agency should not use differing time spans for the baseline and performance periods to achieve longer measurement periods at the expense of introducing seasonality issues. We instead recommend that the agency shorten the baseline period for the first year to correspond to the performance period in order to avoid any issues with quality measure seasonality. That is, CMS should use corresponding calendar quarters for the

baseline and performance periods, both of which should be at least six months long. For example, CMS could use a baseline period of 3rd and 4th quarter 2010 and a performance period of 3rd and 4th quarter 2011 (see fig. 2). In subsequent years of the VBP program, when such time pressures have been alleviated, we recommend CMS use a full 12 months of data for both the baseline and performance periods.

Figure 2: Fiscal Year 2013 VBP Timeline with Six-month Performance Period



If, as seems likely, some or all of the baseline period selected by CMS for the initial year of the VBP program already has commenced by the time the VBP final rule is published, we ask CMS to exclude from the first year of the program those hospitals that do not have baseline data because they were not participating in the hospital inpatient quality reporting program. These hospitals should not be penalized under the VBP program for not having performance data during this time period because they could not have known the timing of the initial baseline period. They simply should be excluded from the initial year of the program and no funds should be withheld from their usual payments.

VBP INCENTIVE PAYMENTS

Implementation of the VBP program represents a substantial change in how hospitals will be paid under the Medicare program. The financial incentives tied to hospital performance can be distributed in several ways, each of which could have a different effect on hospitals' abilities to use the payments to implement quality improvement activities.

While it may seem the simplest approach to attach a portion of each hospital's VBP incentive to each of its discharges, this will result in hospitals receiving a very small portion of their overall VBP incentive with each Medicare claim. Thus, we caution CMS against this approach, which could dilute any immediate and significant effect the VBP program may have on hospital performance. Attaching such a small amount of funds to an already-existing payment is not likely to lead to hospitals identifying it as a performance incentive that should be used to further improve quality. Rather, it is likely to get "lost" in the pool of overall Medicare payments.

In contrast, using a lump-sum approach to distribute VBP incentives would help ensure that the VBP program immediately and significantly impacts hospital performance in a manner that improves the quality of care. Because a lump sum payment would be a dedicated and much more visible pool of funds, it would help hospitals identify it as an incentive and use the payment

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as capital to make investments in quality improvement activities within their facilities. Thus, we recommend CMS estimate each hospital's VBP incentive based on its projected discharges for the fiscal year and provide a majority of the estimated payment, 80 percent, to the hospital at the beginning of that fiscal year. The remainder of the payment should be provided during a reconciliation process at the end of the fiscal year, in keeping with the budget neutrality mandated in the statute.

In addition, as CMS constructs the scale for translating hospital performance into a VBP incentive payment, we urge the agency to consider that requiring a performance rate of 100 percent on quality measures in order to receive the maximum VBP payment is neither necessary nor appropriate. The scale CMS constructs should plateau at the higher end, allowing all hospitals above a certain benchmark to receive back maximum payments. The specific point at which the plateau occurs may vary by quality measure.

We appreciate the opportunity to share these comments and suggestions and look forward to working together to ensure that the hospital VBP program helps continue and improve hospitals' provision of safe, effective, patient-centered, timely, efficient and equitable care to all patients.

Sincerely,

American Hospital Association
Association of American Medical Colleges
Catholic Health Association
Federation of American Hospitals
National Association of Public Hospitals and Health Systems
Premier, Inc.

cc: Dr. Barry Straube, Director, Office of Clinical Standards and Quality & CMS Chief Medical Officer, Centers for Medicare & Medicaid Services
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