American Hospital Association

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Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: ***Options Paper on Medicare Hospital Value-Based Purchasing Plan Development, March 23, 2007***

Dear Ms. Norwalk:

On behalf of our approximately 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) Options Paper on the "Medicare Hospital Value-Based Purchasing (VBP) Plan." We applaud your efforts to continue to reach out to stakeholders as you develop the VBP program, and we gladly share with you our reactions and suggestions. We are very pleased with CMS' acceptance of many of the comments shared by the AHA and other stakeholders in response to CMS' earlier Issues Paper on this topic. We look forward to continuing to engage in a constructive dialogue with the agency on this issue.

America's hospitals are committed to improving quality of care and patient safety as well as achieving better health outcomes. We are dedicated to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients. As a founding member of the Hospital Quality Alliance (HQA), the AHA has been working with hospitals to share with the public reliable, credible and useful information on hospital quality.

The *Deficit Reduction Act of 2005* (DRA) called on CMS to develop a VBP program for Medicare payments to acute care, long-term care, rehabilitation, psychiatric and children's hospitals, with the exception of critical access hospitals. The program's goals are to improve quality and efficiency through financial incentives. While we recognize that VBP may hold merit to help improve hospital performance, we urge CMS to move forward cautiously and to remember that there is no simple resolution to improving health care quality. Past initiatives, including the implementation of the inpatient prospective payment system (PPS) and the

formation of quality improvement organizations (QIOs), were expected to resolve hospital quality issues, but more work remains to be done. We hope that CMS sets realistic expectations for the results of a VBP program.

As the Options Paper demonstrates, a VBP program will be complex. Given the complexity of this issue and the scope of its potential impact, we would appreciate an opportunity to comment on a further draft of the proposal before CMS submits its final report to Congress.

The AHA urges CMS to move cautiously in developing and implementing a program to avoid any unintended consequences that may adversely affect hospitals and the patients they serve. This is particularly important as a number of major regulatory changes are expected in fiscal year (FY) 2009, including continued transition to cost-based weights, a possible new classification system to address patient severity, implementation of the DRA provision on healthcare-acquired infections and potentially significant wage index changes. The additional implementation of a VBP program will be challenging and resource intensive for hospitals.

Our detailed reactions to the Options Paper and suggestions for the VBP program fall into the following seven categories:

- scoring hospital performance
- structure of incentive payments
- reporting measures for inclusion
- transitioning to the VBP program
- data infrastructure and validation
- participation by low-volume hospitals
- public reporting

SCORING HOSPITAL PERFORMANCE

We applaud CMS' proposal to recognize hospitals that attain certain performance thresholds and those that improve their quality scores. Rewarding quality improvement encourages all hospitals to participate in a VBP program and to strive to continually improve their performance. Additionally, rewarding high-performing hospitals for providing excellent, effective care is appropriate.

The AHA has previously recommended to CMS that absolute – rather than relative – thresholds and benchmarks be set for a VBP program. Hospitals need to know in advance the target they must meet to receive an incentive payment. This predictability is important in a PPS and would help ensure that all hospitals that meet the threshold receive an incentive payment. In addition, we have concerns that pay-for-performance systems that provide incentives based on hospitals' relative performance create competition among providers that impedes a collaborative environment in which hospitals share best practices and lessons learned. Therefore, we are pleased to see that CMS has proposed absolute thresholds and benchmarks in the Options Paper. However, we are concerned that CMS' proposal to base performance targets relative to hospitals' prior year performance will not ensure the transparency and predictability that hospitals need. Information on the prior year's performance under current data submission and processing deadlines would not be available until midway through the payment year. Even under CMS' proposed expedited time frame, more than a third of the year will have passed before hospitals know the thresholds and benchmarks that they must meet.

If CMS continues to pursue relative thresholds and benchmarks, the agency should annually publish the next year's targets for each measure. We also urge CMS to allow hospitals access to see both the scale used to score all hospitals on attainment and the scale used to score each hospital's own improvement for each measure before performance scores are finalized each year; this would promote transparency in the scoring system.

CMS notes that each hospital's overall VBP performance score will be based only on the measures applicable to that hospital, given its patient population and the services it provides. While the AHA supports this policy, we urge CMS to institute a formal process whereby hospitals can apply to opt out of measures that are not applicable to their institutions and receive formal, written confirmation of opt-out decisions from CMS prior to the measurement period. A formal opt-out process will assure that the hospital and the agency agree on the performance measures that will be used before the measurement period commences. CMS should strive to develop this formal process in a manner that does not place undue administrative burden on hospitals applying to opt out of certain measures, particularly because such hospitals are likely to be low-volume, smaller hospitals.

STRUCTURE OF INCENTIVE PAYMENTS

The AHA is concerned that CMS' proposal to make the VBP program budget neutral will negatively impact some hospitals. Incentive-based approaches to payment should use a system of rewards – not penalties – to help change behavior. Therefore, the VBP program should be financed using additional funds. Furthermore, CMS should not adopt a minimum performance level and forgo VBP incentive payments to hospitals that fall below that threshold. All hospitals should be recognized for the quality steps they take. Similarly, the AHA supports the option to allocate any residual VBP incentive payments to all hospitals based on their VBP performance scores. We favor a broad distribution of incentive payments, especially in the beginning of a VBP program, to encourage more hospitals to improve their performance and decrease the overall financial risk of the program to hospitals.

The structure of the financial incentives should be as simple and straightforward as possible, particularly as many aspects of the VBP program implementation will be very complex. We believe only the base diagnosis-related group payment, adjusted for geographic wage differences, should be included as the basis of the VBP program incentive payment. In light of other expected changes to the inpatient PPS in FY 2009, it would be extremely difficult for CMS to accurately predict the financial effects of including other components, such as indirect medical education payment, to the VBP financial incentives base.

One issue not addressed in CMS' proposal is the potential impact of counting each measure equally in calculating the incentive. We encourage CMS to examine whether weighting the reporting measures by hospitals' patient volumes can achieve a more equitable scoring system for the VBP program. For example, with this approach, hospitals that perform many surgeries would have their surgical care performance measures carry more weight in their overall performance score compared to hospitals that perform fewer surgeries.

Additionally, we urge CMS to examine the effects of the various proposed payment incentive structures on different hospital sub-groups, such as urban and rural hospitals and teaching and non-teaching hospitals, before selecting an option for implementation.

REPORTING MEASURES FOR INCLUSION

Selecting Measures. The AHA supports CMS' plan to build upon the existing set of measures used in the pay-for-reporting program for the VBP program. We believe that measures elected for the VBP program should be evidence-based, endorsed by the National Quality Forum (NQF) and adopted by the HQA. We agree with CMS that not all measures currently used in the pay-for-reporting program – nor all measures developed in the future – may be appropriate for inclusion in the VBP program, but all measures suitable for VBP should be appropriate for public reporting.

Additionally, the NQF is developing national quality goals. We believe that CMS should look to the NQF goals as a framework for the types of measures that should be included in a VBP program. The HQA has agreed that the NQF's national goals should provide a foundation for its future work. CMS' proposal should indicate its intent to follow the national goals as well.

We agree with CMS' criteria to evaluate the suitability of measures for the VBP program based on their importance, scientific availability, feasibility, improvability, usability, controllability, potential for unintended consequences and contribution to comprehensiveness. We hope that CMS applies these criteria thoroughly and carefully when it considers measures to include in the VBP program. For example, outcomes for the measures for 30-day mortality of heart attack and heart failure patients are not solely within hospitals' control. Social, environmental and cultural factors all contribute to patients' mortality in the community and cannot be managed by a hospital. The results of measures included in a hospital pay-for-performance system should be attributable to the work of the hospital and its clinicians.

Introducing Measures. We generally support CMS' plan that new measures be introduced into the VBP program using a staged approach. When new measures are developed, they should be thoroughly tested and undergo a dry run in the field before they are incorporated into a performance measurement system; hospitals, vendors and the agency must gain experience with the data collection, submission, validation and reporting of new measures before they are linked to an incentive payment. Moreover, CMS should include as a step in its measure development testing and introduction process that measures first be adopted by the HQA. The HQA's rigorous, consensus-based adoption process is an important step to ensure that all stakeholders involved in hospital quality – hospitals, purchasers, consumers, quality organizations, CMS and others – are engaged in and agree with the adoption of a new measure.

We support CMS' proposed three-phased approach of a preliminary data submission period, a public reporting/baseline data period, and a final stage when measures are included for financial incentive, if appropriate. However, VBP measures to be included for financial incentives should be selected during the public reporting period and not during the preliminary data submission period as CMS proposes. We believe that selection of the measures during the preliminary data submission period is premature. We also encourage CMS to provide at least a one-year notice of the implementation of new measures so that systems and processes can be put in place, similar to

CMS' decision to publish FY 2008 pay-for-reporting requirements in the FY 2007 hospital outpatient PPS rule.

The AHA is concerned about the types of measures that CMS proposes to incorporate into the VBP program in FY 2010 and FY 2011, including measures for efficiency, care coordination and patient safety. As yet, measures for these areas have not been developed, endorsed by the NQF or adopted by the HQA, and are unlikely to be ready for inclusion in a VBP program by FY 2010 or 2011. Conversely, measures for pediatric health care quality have been developed, yet are absent from CMS' proposed list of future measures. Although we recognize that pediatric patients rarely are Medicare beneficiaries, CMS should consider including these measures. The VBP program should strive to improve the care of all patients in participating hospitals, not just patients who are covered under Medicare. Finally, the AHA believes it is inappropriate to include emergency care measures and outpatient care quality measures in a VBP program for hospital inpatient payment.

In addition, we would like further clarification from CMS on how it will incorporate data from the Hospital CAHPS (HCAHPS) into a VBP program. The HCAHPS includes 22 individual quality-of-care questions falling into seven domains, including two global questions regarding the patient's overall rating of the hospital. While we agree patients' perceptions of care are important aspects of quality, it is not clear whether they are appropriate for inclusion in a VBP or how CMS plans to include these measures – as one global HCAHPS measure, 22 individual measures, a composite of the seven domains, or some combination of the above. We recommend that CMS examine these data to develop the most suitable way to include HCAHPS information into a VBP program.

Measure Maintenance. As we have previously noted, the current process of reviewing and modifying existing measures every six months is too frequent and can cause problems for hospitals and their vendors. Although we agree with CMS' proposal in the Options Paper to revise this policy, the agency's language stating that it will "periodically reassess measures" is too vague. We believe an annual review of the measures is appropriate. However, exceptions should be made for a major clinical reason to change or suspend a measure. In addition, measures should be suspended when an event beyond hospitals' control, such as an influenza vaccine shortage, precludes their ability to fully perform well on the measure. In reviewing the measures, CMS should take into account the ability of hospitals to successfully and quickly implement changes in reporting measures when it considers making revisions. To understand the effects that reporting changes have on hospitals, CMS should seek input from hospital data collection personnel as a part of the measure review process.

TRANSITIONING TO THE VBP PROGRAM

Given the complexity of the VBP program and the significant resource investment required by hospitals and CMS to implement the program, we urge CMS to recommend phasing in the transition from the current hospital pay-for-reporting program to the VBP program over several years. The Options Paper offers one- and three-year options, but VBP represents a truly significant change in public policy. Pay-for-performance experiments have had mixed results thus far, sometimes with surprising or unintended effects. We applaud CMS' stated commitment to identify and address these effects, but we believe it would be wise to transition to a VBP

program slowly and judiciously, allowing time to adjust in the event of unintended consequences.

DATA INFRASTRUCTURE AND VALIDATION

We are pleased that CMS recognizes that the existing data infrastructure must be modified and strengthened to fully support the VBP program. We urge the agency to work with a broad group of stakeholders to develop solutions to the current system limitations. In particular, the HQA should be a central entity in working with CMS to modify and refine the data infrastructure.

Data Submission Timeline. The AHA does not support compressing the data submission timeline to 60 days because hospitals will be unable to complete data abstraction within that timeframe. For many hospitals, the billing process for some claims exceeds 60 days. The AHA has serious concerns about the ability to collect accurate data in such a tight timeframe. Additionally, CMS must be able to assure hospitals that updated software used to collect data will be available on the first day of the data submission period. Previously, delays in the availability of useable software have caused data submission delays for hospitals. Unless the current software problems can be resolved, the timeline cannot be shortened. Hospitals also have reported difficulties obtaining assistance from the QualityNet Help Desk during critical times in the data reporting process because it has been overwhelmed with inquiries. More resources are needed for the QualityNet Help Desk.

Data Submission Feedback and Data Resubmission. We recommend that CMS redesign the data submission feedback reports to provide hospitals with useable, real-time data that can aid them with their data submissions and assist them with quality improvement efforts. We support CMS' recognition that a data resubmission process is needed for hospitals and their vendors if they discover an error in their data during the submission process.

Data Validation. We appreciate CMS' decision to accept our suggestion to conduct an annual audit of a random sample of hospitals, in addition to targeted audits of outliers, for the purpose of validating hospital data. We are currently examining options for conducting the audits as well as methods the agency can use to validate the data. We will share the results of our analyses with you when they are completed. We also support the proposal that the validation and appeals process be conducted post-payment to avoid delays in incentive payment adjustments and public reporting. For many hospitals, a delay in receiving expected payments may be a hardship and could negatively impact planned quality improvement or patient safety activities. However, improvements must be made to the current appeals process so that it is straightforward, transparent and timely. Hospitals should have clear guidance on how to submit their appeals, and CMS should expedite its appeals decisions.

We believe it is inappropriate that hospitals that fail an audit would have their performance results unequivocally suppressed for reporting on *Hospital Compare* for 12 months. Suppressing a hospital's results suggests that the posted performance is significantly different from that which would have resulted from accurate data. We would support the suppression of performance results only if the accurate results are significantly different from the posted results and only for as long as necessary to gather and post accurate data.

Single Hospital Quality Data Repository. The AHA supports the concept of a single hospital quality data repository that minimizes the administrative burden on hospitals and that allows all users easy access to needed data, with appropriate protections for patient privacy. As more insurers and other organizations engage in VBP or seek to collect quality data to inform consumers, it will become more burdensome for hospitals to collect and report on different measures that use different parameters. Providers also are likely to be confused about their performance as they see disparate data reports from different organizations. The existence of multiple hospital quality data repositories therefore would be inefficient and a burden on the health care system, and the resulting confusion would likely dampen quality improvement activities.

A single, comprehensive source of information to compare hospitals would help to resolve these problems as long as it:

- enables accrediting bodies, insurers, consumers and others to have broad access to the quality data;
- ensures that the data are reliable and valid;
- enables collection of a broad array of patient data, regardless of age, gender, or insurer;
- provides a clear vehicle for updating measures when new scientific information affecting the measures emerges;
- minimizes burden on providers; and
- maximizes efficiency for all stakeholders.

We hope that as CMS considers a single data repository and infrastructure, the agency will acknowledge the significant challenges of using the QIO network for this purpose. To ensure the highest quality in the data collection and reporting process, CMS should select the best quality data repository. CMS should work with other stakeholders to ensure that the chosen repository will meet the needs and expectations of those who will be using it, such as hospitals, insurers, consumers and HQA participants.

PARTICIPATION BY HOSPITALS WITH LIMITED DATA

The AHA supports a program that allows all hospitals to publicly report their quality data and demonstrate their achievements. We believe public reporting can spur positive changes in health care delivery and reduce disparities in care. However, we encourage CMS to develop a VBP program that fairly accommodates hospitals' varying abilities to report on quality measures. We appreciate CMS' recognition that because some hospitals may have limited data available for reporting, their data may not be statistically stable or sufficiently indicative of their real performance to enable meaningful participation in a program that pays based on performance data. With CMS' agreement, such hospitals could continue in the public reporting portion of the VBP program but opt out of the pay-for-performance portion of the program. Any hospitals that are excluded from the VBP program should not see their payments reduced to fund the program.

We urge CMS to explore program design options that enable all hospitals included in a VBP program to have an equal opportunity to do well. The design in the current Options Paper may put general acute care hospitals, which deliver a wide range of services to all types of patients, at a disadvantage because they must do well on a broad array of measures to qualify for a full

incentive payment, while hospitals with a more limited scope of services must do well on a much smaller set of measures. CMS should consider options to eliminate this inequity. For example, CMS could consider funding the VBP program and rewarding hospitals on a DRG-specific basis. Under this approach, hospitals would see their base DRG payments increased or decreased only for those DRGs related to the measures on which they are reporting for pay-for-performance. Also, as we mentioned above, weighting the reporting measures by hospitals' patient volumes may achieve a more equitable scoring system among hospitals. The AHA looks forward to working with CMS on designing a VBP program that can address these equity issues among all hospitals, particularly those with limited data.

PUBLIC REPORTING

The AHA continues to support CMS' intent to build upon the existing *Hospital Compare* Web site for publicly reporting hospital performance under the VBP program. Regarding CMS' solicitation for comments on the design, tailoring and testing of decision-support tools and consumer-friendly enhancements to the *Hospital Compare* Web site, we urge the agency to work with the HQA to study these issues and further refine and develop the Web site's capacities. Thank you for the opportunity to provide our reactions to the Options Paper. If you have any questions, please feel free to contact me or Nancy Foster, vice president for quality and patient safety, at (202) 626-2337 or nfoster@aha.org.

Sincerely,

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Cc: Robin Phillips, Medicare Feedback Group