

March 1, 2011

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1498-IFC2
P.O. Box 8013
Baltimore, MD 21244-1850

***RE: CMS-3239-P, Medicare Program; Hospital Inpatient Value-Based Purchasing Program;
Proposed Rule (Vol. 76, No. 9), January 13, 2011***

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposal for a hospital inpatient value-based purchasing (VBP) program.

Hospitals are committed to improving the quality and safety of the care that they provide every day, as well as to the concept of aligning payment with the delivery of high-quality patient care through a pay-for-performance system. The AHA supports the general direction of CMS' proposed rule, but has serious concerns about specific proposals, such as the inclusion of hospital-acquired conditions in the VBP program, the weighting of the patient experiences of care survey data, and the required minimum number of patient cases to participate in the program.

PROPOSED PERFORMANCE PERIOD

The *Patient Protection and Affordable Care Act of 2010* (ACA) sets out certain parameters regarding the timing of implementation of the VBP program. First, the VBP program must begin 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 program begins. Finally, CMS must announce the standards that will be used to assess hospital performance at least 60 days before the performance period begins.



For the first year of the VBP program, for both the clinical process and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experiences with care measures, CMS proposes a nine-month baseline period of July 1, 2009 through March 31, 2010, and a nine-month performance period of July 1, 2011 through March 31, 2012. CMS states that in future years, it anticipates proposing 12-month baseline and performance periods for the clinical process and HCAHPS measures. **We support CMS' proposals for the fiscal year (FY) 2013 baseline and performance periods, which are both as long and as recent as possible under the ACA-mandated timeframes.**

For the mortality measures that CMS proposes to include in the VBP program beginning in FY 2014, the agency proposes a performance period of July 1, 2011 through Dec. 31, 2012, with a baseline period of July 1, 2008 through Dec. 31, 2009. As noted below, we do not support inclusion of the mortality measures in the VBP program for FY 2014. However, we remain concerned about the proposed use of 18-month performance and baseline periods. First, this 18-month proposed time period is shorter than the current three-year period used for the *Hospital Compare* data display. Second, in each subsequent year of the VBP program, the 18-month performance and baseline periods will move forward only 12 months, meaning that the periods will overlap between two adjacent payment years. This is inappropriate. Under the VBP program, hospitals are being scored on their quality improvement from year to year and their achievement in a given year. Implementing performance and baseline periods that overlap from year to year will severely dilute the amount by which hospitals' actual improvements and achievements are recognized by CMS' scoring methodology. It also will compress hospitals' relative scores, thereby distorting incentive payments. **We urge CMS to fully recognize hospitals' improvements and achievements by implementing 12-month (nine-month for FY 2013) performance and baseline periods for all measures included in the VBP program.**

PROPOSED MEASURES

CMS discusses the measures that it proposes to incorporate in FYs 2013 and 2014 of the VBP program.

FY 2013 PROPOSED MEASURES

For FY 2013, CMS proposes to include in the VBP program 17 clinical process measures, as well as the results of the HCAHPS survey. The selected clinical process measures include three measures of heart attack care, three measures of heart failure care, four measures of pneumonia care, three measures of surgical care, and four measures of healthcare-associated infections/surgical care. The AHA agrees that the measures selected are appropriate for inclusion in the VBP program, as all have been endorsed by the National Quality Forum (NQF) and adopted by the Hospital Quality Alliance (HQA). However, we suggest that CMS ensure that the measures selected for the VBP program are important measures that accurately and reliably assess meaningful aspects of care. To make this determination, we suggest that CMS look to criteria recently developed by The Joint Commission to define excellent quality measures, which they refer to as accountability measures. The Joint Commission has spent time

examining what makes some measures better than others and concluded that accountability measures:

- are measures for which there is a large volume of research linking the measure to improved outcomes;
- accurately assess whether evidence-based care has been delivered;
- addresses a process that is close in proximity to the desired outcome; and
- that implementation of the measure has minimal unintended adverse consequences.

The ACA stipulates that the VBP program include healthcare-associated infection measures. For FY 2013, CMS has designated four of the surgical care measures to fulfill this requirement because the measures relate to preventing infections post surgery. The AHA agrees with the proposal to include these measures in the VBP program as healthcare-associated infection measures. We agree with CMS that the measure of timing of antibiotic administration for pneumonia patients should not be included. There continue to be concerns of unintended consequences with the use of this measure, namely that some patients who it is later determined would not benefit from antibiotics are still receiving the drugs within the short timeframe specified in the measure. The AHA also agrees with CMS' decision not to include the structural measures in the VBP program.

CMS proposes to exclude from the program seven measures that are “topped out” measures for which hospital performance was statistically indistinguishable at the 75th and 90th percentiles and for which the truncated coefficient of variation was less than 0.10, meaning that hospitals' scores were tightly clustered around the average score. We agree that these statistical tests have the potential to identify measures for which it would be extremely difficult to identify any meaningful differences among hospitals' performance. However, when we calculated the achievement threshold and benchmark scores using the *Hospital Compare* dataset that most closely matches CMS' proposed baseline period, we found several measures for which hospitals' scores were still clustered at a high level of achievement. See Table 1 for a list of the national thresholds and benchmarks for each measure.

Table 1: Calculation of Thresholds and Benchmarks Using Most Recent Hospital Compare Data

<u>Measure ID</u>	<u>Measure Description</u>	Median (Achievement Threshold)	Mean of Top Decile (Achievement Benchmark)
AMI-2	Aspirin at discharge	0.98	1.00
AMI-7a	Fibrinolytic therapy received within 30 minutes of hospital arrival	0.67	0.85
AMI-8a	Primary PCI received within 90 minutes of hospital arrival	0.85	0.99
HF-1	Discharge instructions received	0.86	1.00
HF-2	Evaluation of LVS function	0.98	1.00
HF-3	ACEI or ARB for LVSD	0.94	1.00
PN-2	Pneumococcal vaccination	0.92	1.00

PN-3b	Blood culture performed prior to administration of first antibiotic(s)	0.95	0.99
PN-6	Initial antibiotic selection for CAP in immunocompetent patient	0.91	0.98
PN-7	Influenza vaccination	0.91	1.00
SCIP-Inf-1	Prophylactic antibiotic(s) one hour before incision	0.95	0.99
SCIP-Inf-2	Selection of antibiotic given to surgical patients	0.98	0.99
SCIP-Inf-3	Prophylactic antibiotic(s) stopped within 24 hours after surgery	0.92	0.99
SCIP-Inf-4	Cardiac surgery patients with controlled 6AM postoperative serum glucose	0.92	0.99
SCIP-VTE-1	Surgery patients on a beta blocker prior to arrival who received a beta blocker during the perioperative period	0.93	0.99
SCIP-VTE-2	Surgery patients with recommended venous thromboembolism prophylaxis ordered	0.91	0.99
SCIP-Card-2	Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery	0.92	1.00

Medians and means of top decile are calculated using the December 2009 *Hospital Compare* data (including discharges from April 2008 to March 2009). Hospitals with fewer than four applicable measures or 100 HCAHPS surveys are excluded.

In particular, aspirin at discharge, evaluation of LVS function and antibiotic selection for surgical patients show threshold and benchmark scores that are very close together. For these measures, the national median scores are 0.98 and the national benchmark scores are 0.99 or 1.00. This presents a problem when attempting to calculate the achievement scores for these measures. For example, a hospital scoring 0.98 would receive 1 point for achievement for scoring at the threshold. A hospital scoring 0.99 or higher would receive 10 points for achievement for scoring at the benchmark. Yet, there is no way for a hospital to score any number of points between 1 and 10 on the achievement range. This seems to go against CMS' intent to exclude topped out measures. It also could be particularly challenging to those hospitals that CMS proposes to score only on achievement because they do not have data for the baseline period. We suggest that the solution to this problem is to change the method used for setting the achievement thresholds and benchmarks, which we discuss in further detail below.

FY 2014 PROPOSED MEASURES

CMS proposes adding the 30-day heart attack, heart failure and pneumonia mortality measures in FY 2014. In addition, the agency proposes adding nine patient safety and inpatient quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) and eight measures of hospital-acquired conditions (HACs). The HAC measures are the same ones included in the current inpatient prospective payment system (PPS) HAC policy and also are identical to the measures defined in Section 3008 of the ACA, which would financially penalize hospitals with high rates of HACs. **The AHA strongly opposes the inclusion of HAC**

measures in both the VBP program and the HAC policy because of the opportunity for hospitals to be penalized twice on the same measures.

Further, we do not believe that the current format of the HAC measures allows for valid comparisons among hospitals. Good measures of adverse safety events reliably count the number of times an event occurred in the numerator and have a denominator that accurately counts the number of patients at risk for that occurrence. Further, they make appropriate adjustments for occurrences that happened before the patient was hospitalized or that could not have reasonably been prevented by the hospital. The formula used by CMS for the HAC calculations includes only those events that were recorded in the medical record in a way that could be recognized and coded by a clerk. However, physicians have various ways of describing symptoms that are helpful to them in treating the patient, but might not be readily identified by the coders. Further, CMS is choosing to use the number of Medicare fee-for-service patients as the denominator for all but one of these events, but that misrepresents which patients are really at risk for many of them. For example, only patients with urinary catheters would be at risk for a catheter-associated urinary tract infection.

The HAC measures portray an incomplete picture of the care delivered by hospitals. The patient population captured by the measures is limited to the Medicare fee-for-service population. Further, the Medicare claims system does not allow for capture of more than eight secondary diagnoses, but many Medicare patients have more than eight diagnoses. Thus, the limitations of Medicare's own data system do not take into account the occurrence of some events that may have been recorded in ninth place or lower.

Further, the ACA requires that CMS risk-adjust the HAC measures to be used for Section 3008. Risk adjustment is critical to account for the differences in patient populations among hospitals. Without using a risk-adjustment methodology, hospitals that admit a higher proportion of sicker patients, who are more at risk for some of the conditions, will unfairly bear a larger financial penalty. The HAC measures that CMS proposes to use, those it adopted in the FY 2011 inpatient PPS final rule, are not risk-adjusted. Therefore, CMS must either modify the measures at a later date to be compliant with the statutory requirements in Section 3008, or use and publicly report two different versions of the HAC measures, one version for the VBP program and another for Section 3008. This would add unnecessary complexity and confusion for hospitals and the public. **In summary, because of the duplicative nature of Medicare payment policies around HACs and the poor construction of the current HAC measures, these measures should not be included in the hospital VBP program.**

We suggest that the Centers for Disease Control and Prevention's (CDC) measures assessing central line-associated bloodstream infections (CLABSI) and surgical site infections (SSI) would be more appropriate outcomes measures for future inclusion in the VBP program. Since January 2011, hospitals have been submitting information on CLABSI rates through the CDC's National Healthcare Surveillance Network (NHSN) for the Medicare hospital inpatient quality reporting program. Hospitals will begin reporting on SSI rates in January 2012. The CDC measures are well-developed, scientifically sound, accepted by clinicians and derived from clinical data. All of these attributes make them far more accurate in assessing hospitals' performance than the

HAC measures. In addition, the CDC measures have been endorsed by the NQF and adopted by the HQA.

At this time, we urge CMS not to include the mortality measures in the VBP program until the risk-adjustment methodology is further refined. We are concerned with incorporating the mortality measures and AHRQ patient safety and quality indicators into the VBP program. While we would like to see greater incorporation of outcomes measures into the Medicare pay-for-reporting and VBP programs, we believe that the mortality measures and the AHRQ indicators have methodological weaknesses that must be refined before these measures are included in the VBP program. Currently, the mortality measures do not exclude patients who are receiving palliative care only in the hospital. The fact that palliative care patients are not excluded can skew the mortality measure results for some hospitals. Hospitals that run large palliative care programs will have higher mortality rates. It would be inappropriate for such hospitals to be penalized under VBP for their ability to provide high-quality, patient-directed end-of-life care.

The AHA believes that while some of the AHRQ indicators may be appropriate for public reporting, they lack the sensitivity and specificity required for use in a VBP program. Because they are derived from administrative data, they are less sensitive to identifying all relevant patients, and excluding other patients, than measures derived from clinical chart abstraction. Some of the AHRQ indicators have a very high false positive rate, meaning that they indicated potential problems, but further investigation showed the care was fine, and the indicator was wrong. To be considered ready for implementation in the VBP program, these measures need additional field-testing and respecification. **Thus, at this time, we urge CMS not to include the AHRQ indicators in the VBP program.**

The AHRQ patient safety indicator (PSI) composite measure includes all of the proposed individual PSI measures, along with other measures not specifically proposed by CMS. Although the PSI composite measure is NQF endorsed, six of the 11 individual PSI measures have not been NQF endorsed. If CMS follows the current AHRQ methodology to calculate the PSI composite measure, the five measures proposed will account for 60 percent of the weighted composite. Thus, it appears that these measures will be double counted for determining both the performance standards and hospitals' scores. **We urge CMS not to include the AHRQ PSI composite in the VBP program.** Similarly, the AHRQ inpatient quality indicator (IQI) composite mortality measure for selected medical conditions includes the hip fracture mortality measure among seven other IQI mortality measures. Thus, the hip fracture mortality measure also would be double counted in the scoring methodology. **Again, we urge CMS not to include the AHRQ IQI composite mortality measure in the VBP program.**

PROPOSED SUBREGULATORY PROCESS

CMS proposes to add additional measures to the VBP program through a subregulatory process whereby the agency could automatically add any measure to the VBP program once it has been used for the pay-for-reporting program and published on the *Hospital Compare* website for at least one year. CMS notes that a new measure's performance period would begin as soon as the one-year public posting rule has been fulfilled. **The AHA strongly opposes the use of a**

subregulatory process to add measures to the VBP program. There are some measures that may be useful for public reporting but not appropriate for inclusion into a VBP program. For example, “topped out” measures or measures for which the science is still evolving might continue to be useful metrics for public reporting, but not sound enough for use in a VBP program. Interested stakeholders should be able to publicly comment on whether or not CMS has identified appropriate measures for use in the VBP program. Therefore, all measures selected for the VBP program should be put forward in a proposed rule for public comment before they are finalized. CMS’ plan to automatically adopt measures for the VBP program once their one-year publication deadline has passed will lead to a measurement chaos in which every VBP measure has its own unique performance period timeframe. This will be extremely confusing to hospitals trying to use their VBP scores for quality improvement, as the measurement time frame will vary among the measures.

CMS currently modifies measure specifications through a subregulatory process by updating the measure specifications manual twice yearly to reflect changes in science, clinical practice or coding and administrative updates. The AHA believes this process is appropriate and should continue. However, we ask CMS to clarify how it would calculate hospitals’ VBP improvement scores for those years during which a substantial change was made to a measure’s specifications. CMS should articulate clearly what its policy is with regard to calculating improvement scores when a measure, and possibly hospitals’ general performance on that measure, changes from one year to the next.

PROPOSED PERFORMANCE STANDARDS

CMS proposes to establish the clinical process measures’ achievement threshold at the national median, or 50th percentile of performance. CMS proposes to establish the clinical process measures’ achievement benchmark at the mean of the top decile of performance. As shown in Table 1, this would place the benchmark at or near 100 percent for 16 of the 17 clinical process measures. The AHA is concerned that benchmarks at this level are clinically inappropriate. Dale Bratzler, M.D., chief executive officer of the Oklahoma Foundation for Medical Quality, a leading quality improvement organization, has commented extensively on clinically appropriate benchmarks for quality reporting programs. As Dr. Bratzler has stated, measuring perfect care, e.g., 100 percent compliance with a measure, requires the use of perfect quality measures. While the measures proposed for use in the first year of the VBP program are evidence-based and well-developed, they are not perfect. The measures cannot incorporate all clinically relevant exclusion criteria based on every patient’s particular situation.

Asking hospitals to strive for 100 percent compliance on the measures promotes overuse; that is, the provision of treatment to some patients who may not benefit from it. This is a waste of resources and poses some degree of unnecessary risk to the welfare of the patient. In addition, asking hospitals to focus resources toward the challenging task of trying to move their scores on a particular measure from 99 percent to 100 percent redirects those resources from other quality improvement projects, projects that may have more clinical relevance than trying to achieve

perfect scores on individual quality measures. **Because of these challenges, we suggest that CMS change the methodology for calculating the benchmark scores.**

When we assessed alternative benchmark scores at the 90th and 95th percentile, in addition to the mean of the top decile, we found that benchmarks were still compressed at or very near 100 percent. Thus, we suggest CMS reexamine the measures proposed for inclusion in the VBP program or use a different method of setting benchmark scores.

According to our analysis, the achievement thresholds for most measures will be set at or above 0.90. This is problematic for those hospitals that have only 10 patient cases, the minimum number applicable, for a particular measure. If such a hospital were to fail on its performance for a measure by just one patient, the hospital would automatically score below the achievement threshold and would not earn any achievement points for that measure. **This threshold is unfair, and we urge CMS to change the methodology for calculating the thresholds.**

In addition, as we discussed above, CMS' methodology to set the thresholds and benchmarks leads to compression in the achievement range for some measures. This effectively prohibits hospitals from scoring along the achievement range and forces all hospitals into receiving scores of 0, 1 or 10 for achievement on these measures. To resolve this situation, we suggest that CMS ensure that there is at least a 10-point spread between the achievement threshold and benchmark scores.

CMS proposes to include the mortality measures, AHRQ indicators and HAC measures in the VBP program beginning in FY 2014. However, the agency provides virtually no detail on how it proposes to score hospitals' performance on these measures. We urge CMS to propose a scoring methodology for these measures in future rulemaking. It is critical that the public be given an opportunity to weigh in on proposed scoring methodologies for outcomes measures. As mentioned earlier, we believe CMS' proposal to use an 18-month performance period for the mortality measures is inconsistent with the current reporting timeline and will cause confusion, as the part of the performance period will overlap from one fiscal year to the next. We urge the agency to use a 12-month performance period for all VBP measures. In addition, from the brief presentation of the sample achievement thresholds presented in the rule for the mortality measures, it appears that CMS will not take hospitals' confidence intervals for these measures into account when calculating performance. The confidence intervals are a central component of the methodology for the mortality measures and should be considered when determining hospitals' performance on these measures for the purposes of the VBP program.

Finally, we urge CMS to make a technical clarification with regard to how the achievement thresholds and benchmarks are calculated. In the proposed rule, it is unclear whether hospitals were included in the calculation of the benchmarks and achievement thresholds only if they had at least four clinical process of care measures with 10 or more cases *and* at least 100 HCAHPS surveys in the baseline period, or whether meeting only one of these criteria was sufficient for inclusion. We suggest CMS include hospitals in the benchmark and achievement threshold calculations only if they meet both of the minimum criteria, as these are the only hospitals that will be included in the VBP program.

PROPOSED METHODOLOGY FOR CALCULATING THE TOTAL PERFORMANCE SCORE

The AHA agrees with the statutory requirement that hospitals should receive credit for achieving high performance as well as for improving their performance, and a hospital's VBP score on any individual measure should reflect the higher of its achievement and improvement scores. In discussing the VBP scoring methodology, CMS notes in the proposed rule that it is important that the methodology be straightforward and transparent to hospitals, patients and other stakeholders. While we believe CMS' methodology has been thoughtfully and carefully developed, there are certain steps in the calculations that can be simplified to make the methodology easier for all to understand. We outline those specific recommendations below.

CLINICAL PROCESS OF CARE AND OUTCOME MEASURES SCORING

To calculate achievement scores for each measure, CMS proposes to assign a hospital points along a range between the achievement threshold and the benchmark:

- If a hospital's score is equal to or greater than the benchmark, the hospital would receive 10 points for achievement;
- If the hospital's score is less than the achievement threshold, the hospital would receive zero points for achievement; and
- If the score is equal to or greater than the achievement threshold but below the benchmark, the hospital would receive a score of 1-9 based on where its score falls on the scale between the achievement threshold and the benchmark according to the following formula:

$$9 \times \left(\frac{\text{performance period score} - \text{achievement threshold}}{\text{benchmark} - \text{achievement threshold}} \right) + 0.5$$

All achievement scores would be rounded to the nearest whole number.

Under CMS' proposed formula, a hospital with a score equal to the achievement threshold would receive a score of 0.5, which rounds to 1. A hospital with a score equal to the benchmark would receive a score of 9.5, which rounds to 10.

The proposed formula achieves CMS' stated objectives, but essentially creates a scale of 0.5 to 9.5, instead of a scale of 1 to 10, for hospitals with scores from the achievement threshold to the benchmark. We acknowledge that the scale should only run to 9.5 so that only hospitals obtaining the benchmark score receive the maximum of 10 points. **However, we urge CMS to modify its formula so that the scale starts at 1 instead of 0.5. We believe doing so will be more simple and straightforward to hospitals and others, which is in keeping with CMS' goals for the VBP program. Such a formula would be:**

$$8.5 \times \left(\frac{\text{performance period score} - \text{achievement threshold}}{\text{benchmark} - \text{achievement threshold}} \right) + 1$$

In determining the improvement score, hospitals would receive points along a range between the hospital's score during the baseline period and the benchmark score:

- If the hospital's score is lower than its baseline period score on the measure, the hospital would receive zero points for improvement; and
- If the score is greater than the baseline period score but below the benchmark, the hospital would receive from 0-9 points based on where its score falls on its own unique improvement range, according to the following formula:

$$10 \times \left(\frac{\text{performance period score} - \text{baseline period score}}{\text{benchmark} - \text{baseline period score}} \right) - 0.5$$

All improvement scores would be rounded to the nearest whole number.

Under CMS' proposed formula, a hospital with a score equal to its baseline period score would receive a score of *negative* 0.5, which rounds to 0. A hospital with a score equal to the benchmark would receive a score of 9.5, which rounds to 10.

The proposed formula achieves CMS' stated objectives, but essentially creates a scale of *negative* 0.5 to 9.5 for hospitals with scores from their baseline period score to the benchmark. We acknowledge that the scale should run only to 9.5 so that only hospitals obtaining the benchmark score receive the maximum of 10 points. However, we believe it is inappropriate to start the scale at *negative* 0.5. For hospitals to improve enough to earn one point for improvement, they would first have to "dig" themselves out of this hole of negative points. Hospitals that maintained their baseline period scores, or improved only small amounts, should not have negative scores – it is discouraging and creates an inappropriate perception.

CMS' proposed formula is also more complex than one for a scale that runs from 0 to 9.5. Thus, we urge we urge CMS to modify its formula so that the scale starts at 0 instead of *negative* 0.5. **We believe doing so will be more equitable, simple and straightforward to hospitals and others, which is in keeping with CMS' goals for the VBP program. Such a formula would be:**

$$9.5 \times \left(\frac{\text{performance period score} - \text{baseline period score}}{\text{benchmark} - \text{baseline period score}} \right)$$

To calculate a hospital's overall score within the clinical process of care measures domain, CMS would sum the points earned for each measure and divide that number by the total possible points that the hospital could have earned for that domain based on the number of applicable measures that the hospital had. Thus, all of the measures within the domain would receive equal weighting in the calculation of the domain score. The AHA agrees that equally weighting measures within a domain is the appropriate approach at this time. As the science of quality measurement evolves, we may find that certain measures have a greater impact than others on patient outcomes. If that is the case, those measures likely should receive a higher weighting in

the VBP scores calculation. However, as such effects are unknown at this time, equal weighting of all measures in the appropriate approach.

While CMS has noted in the heading of this section of the rule that it is describing the method for calculating scores in both the clinical process of care measures domain and the outcomes measures domain, no examples are given of scoring for any of the outcomes measures that CMS proposes to add beginning in FY 2014. The scoring for all of the proposed outcomes measures is different from that of the clinical process of care measures. For example, the clinical process of care measures assess care processes that patients should receive. In contrast, all of the outcomes measures assess the occurrence of events that should not occur – such as a patient death or the experience of an adverse patient safety event. It is unclear from the rule how CMS would apply the scoring formulas to the outcomes measures. **We strongly urge CMS to lay out in a future proposed rule how it would apply the scoring models to the outcomes measures before adding those measures to the VBP program.**

SCORING PATIENT EXPERIENCE OF CARE MEASURES (HCAHPS)

CMS proposes that HCAHPS scores be calculated similarly to scores for the clinical process measures, but the HCAHPS scores also would include a component for assessing the hospital's consistency. To assess hospitals on their HCAHPS scores, CMS proposes to use the HCAHPS "dimensions" that are reported on *Hospital Compare* (e.g., the categories for nurse communications, communication about medications, etc.) with two exceptions. First, the agency proposes to combine the "cleanliness" and "quietness" ratings into one category. Second, it proposes not using the "recommend the hospital" item.

For each HCAHPS dimension, the score would be based on the proportion of best category, or "top-box," responses. For example, the hospital's score on nurse communication would equal the proportion of patients who replied that their nurses "always" communicated well. For each HCAHPS dimension, CMS proposes establishing a minimum achievement threshold equal to the median, or 50th percentile, top-box score among all hospitals during the baseline period. The agency proposes to set the benchmark at the 95th percentile of performance during the baseline period.

To calculate achievement scores for each HCAHPS dimension, CMS would assign a hospital points along the range between the achievement threshold and the benchmark.

- If a hospital's score on a dimension is equal to or greater than the benchmark, the hospital would receive 10 points for achievement.
- If the hospital's score on a dimension is less than the achievement threshold, the hospital would receive zero points for achievement.
- If the score is equal to or greater than the achievement threshold but below the benchmark, the hospital would receive a score of 1-9, rounded to the nearest whole point, based on where its performance falls on a scale between the achievement threshold and the benchmark according to the following formula:

$$\left(\frac{\text{HCAHPS performance period dimension score} - 50}{5} \right) + 0.5$$

To calculate HCAHPS improvement scores, hospitals would receive points along an improvement range, a scale between the hospital's prior score during the baseline period and the benchmark score.

- If the hospital's dimension score is lower than its baseline period score on the measure, the hospital would receive zero points for improvement.
- If the score is greater than its baseline period score but below the benchmark, the hospital would receive a score of 0-9 based on where its performance falls on its own unique improvement range according to the following formula:

$$10 \times \left(\frac{\text{HCAHPS performance period dimension score} - \text{HCAHPS baseline period dimension score}}{\text{benchmark} - \text{HCAHPS baseline period dimension score}} \right) - 0.5$$

The methodology to calculate hospitals' performance on HCAHPS differs from the methodology used to calculate hospitals' scores on the clinical process measures. For the clinical process measures, hospitals' actual scores are compared against the median score for the achievement threshold and the mean score of the top decile of scores for the achievement benchmark. The HCAHPS methodology requires that hospitals' scores be translated first into percentiles of performance and then compared to the thresholds and benchmarks. The AHA believes that the HCAHPS scoring is overly complex and should be simplified.

The translation of hospitals' scores into percentiles is analytically challenging. Many hospitals achieve the same score on a given HCAHPS dimension, which leads to many "ties" when trying to determine their percentile rankings. This can lead to some inaccurate assumptions in assigning hospitals VBP points unless controlled for carefully. For example, say the median score on the nursing communication dimension was 0.75. When you use SAS or Excel, common statistical analysis software programs, to assign percentile ranks to the scores, the fact that there are numerous hospitals with a score of 0.75 causes the software programs to default to the lowest percentile rank and assigns it to all of the hospitals with that score. When the AHA replicated CMS' methodology, the software programs assigned hospitals scoring 0.75 (the median percentile) a percentile ranking of 0.44. This would erroneously place these hospitals below the median percentile and, thus, they would not get any achievement points.

Also, under CMS' proposed methodology, it is our understanding that the performance period scores are being assigned percentile ranks at the baseline, i.e., what would the score have ranked had it been present in the baseline. However, there are some hospitals whose performance period scores have no comparable baseline period comparison. In such instances, a percentile ranking cannot be assigned to that hospital's score. This is a problem inherent with using the percentile methodology, and it is unclear how CMS worked around this issue. For example, in AHA's modeling of the VBP proposed rule, we identified providers with scores of 90 percent in the performance period for the medicine and pain management components of HCAHPS. However,

there were no providers in the baseline period that had scores of 90 percent. Therefore, it is impossible to know what percentile a score of 90 percent would have been in if it were present in the baseline period.

In sum, converting the raw scores into percentiles or ranks of hospitals may not lead to the same results as if the scoring is done in the same manner as it is for the clinical process measures. It also causes complicated methodological problems that are not easily resolved. Thus, **the AHA strongly urges CMS to change the HCAHPS methodology and calculate the HCAHPS achievement and improvement points in the same manner as it proposes to calculate the achievement and improvement points for the clinical process measures— directly from hospitals’ scores on the measures. Doing so will be more simple, straightforward and transparent to hospitals and others, which is in keeping with CMS’ goals for the VBP program.**

There is an additional inconsistency with calculating the HCAHPS achievement scores, as proposed by CMS. The common format for calculating the clinical process measures achievement score is (performance period score – achievement threshold)/(benchmark – achievement threshold). Similarly, the common format for calculating both the clinical process measures and HCAHPS improvement scores is (performance period score – baseline score)/(benchmark – baseline score). However, the format for calculating HCAHPS achievement is (performance period score – 50)/5. It is unclear why this formula is different from the others. **We urge CMS in the final rule to make the format of the calculation of the HCAHPS achievement score consistent with the other formulas or provide a clear explanation of why it must be different.**

CMS proposes to evaluate hospitals also on the consistency of their HCAHPS scores. Hospitals would be able to earn 0-20 points for consistency. To calculate the “HCAHPS consistency score,” CMS would assign points based on each hospital’s lowest score among the eight HCAHPS dimensions. Specifically, the hospital’s lowest score during the performance period would be compared to all hospitals’ performance during the baseline period, and the hospital would be assigned consistency points based on its percentile ranking, rounded to the nearest whole number, based on the following formula:

$$2 \times \left(\frac{\text{lowest percentile}}{5} \right) - 0.5$$

To determine the total number of VBP points earned by a hospital for its HCAHPS scores, CMS would sum the points earned by the hospital on each of the eight HCAHPS dimensions and divide that number by 80, the total number of points possible. CMS proposes to add to that score the number of consistency points earned by the hospital for a maximum number of 100 possible HCAHPS points. This methodology is different from that of the clinical process measures domain, for which the total points equals the sum of all of the points earned divided by the total possible points. It is unclear why CMS is proposing to include the consistency score for the HCAHPS domain. There is no rationale provided in the proposed rule as to why consistency is

more important for patient experiences with care measures than clinical process measures. We have been unable to determine any value or increased incentive to hospitals that the consistency score might add. It adds another layer of complexity to the scoring methodology without any apparent justification. **Therefore, we urge CMS to drop the consistency score from the HCAHPS measures calculations. Instead, the agency should determine a hospital's total HCAHPS points simply by summing the total number of points earned across the eight dimensions and by dividing by 80.**

WEIGHTING OF HOSPITAL PERFORMANCE DOMAINS AND CALCULATION OF THE HOSPITAL VBP TOTAL PERFORMANCE SCORE

In determining hospitals' overall scores, CMS proposes first to group the clinical process measures into one "domain" and the HCAHPS dimensions into another "domain." A score would be calculated for each domain by summing the individual measure scores within that domain, weighting each measure equally. **However, instead of weighting each measure equally, we urge CMS to consider weighting measures by "opportunities to provide care," where a hospital's denominator for each domain 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. Doing so encourages hospitals to focus first on improving or achieving high quality where they have the most cases, thereby improving care for the most patients.

CMS proposes to combine the scores for the two domains to determine a total performance score. For FY 2013, CMS proposes that the clinical process measure domain would account for 70 percent of the hospital's score and that the HCAHPS domain would account for 30 percent of the hospital's score. However, we are concerned that the weighting for the HCAHPS domain is inappropriately high. While much work has gone into developing the HCAHPS measures, new research is emerging that shows that HCAHPS scores may be impacted by patient characteristics more than previously thought. For example, research conducted by the Cleveland Clinic has shown that as patients' severity of illness worsens, HCAHPS scores decline in a statistically significant manner. The same relationship was observed when the researchers examined the relationship between patients' symptoms of depression and responses to the HCAHPS questions; as symptoms of depression worsened, HCAHPS scores declined. These findings indicate that hospitals that treat the most severely ill patients may have systematically lower HCAHPS scores. Yet, these patient characteristic variables are currently not adjusted for in the HCAHPS methodology. This unfairly disadvantages hospitals that care for the sickest patients in the proposed VBP program.

The AHA supports surveying patients on their experiences with care and believes it is an important step in advancing patient-centered care. However, we have substantial concerns about using the HCAHPS tool in the VBP program if it systematically disadvantages certain types of hospitals because of the types of patients they serve. We urge CMS to conduct more research to clearly identify and define these potential disadvantages, as well as to determine if improvements to the HCAHPS survey process are warranted, such as making revisions to the sample size requirements and risk-adjustment methodology.

Until then, we strongly urge CMS to reduce the weighting of the HCAHPS domain. For FY 2013, we believe that a weighting of 15 percent strikes a balance between the importance of including a measure of patient experience in the VBP program with the concerns about potential biases present in the survey. The process measure domain should accordingly be weighted at 85 percent.

APPLICABILITY OF VBP PROGRAM TO HOSPITALS

Under the ACA, certain hospitals are excluded from the VBP program. First, non-subsection (d) hospitals are excluded. CMS proposes to define non-subsection (d) hospitals as those outside the 50 states or the District of Columbia, psychiatric, rehabilitation, long-term care, children's, cancer and critical access hospitals (CAHs). In addition, although hospitals in Maryland are considered subsection (d) hospitals, under the ACA, they are exempt from the VBP program so long as the state submits an annual report describing how a similar state program achieves similar goals (which it plans to do). **The AHA supports CMS' proposed definition of non-subsection (d) hospitals.** We ask, however, that the agency clarify whether subsection (d) hospitals that are in CMS demonstrations for their inpatient payment, such as the rural community hospital demonstration, will be included in the VBP program.

Second, per the ACA, CMS proposes to exclude hospitals that do not meet the requirements for the Medicare pay-for-reporting program, that is, hospitals that receive a payment penalty under the pay-for-reporting program. **We support CMS' proposal to exclude hospitals that receive a payment penalty under the pay-for-reporting program from the VBP program,** but we request that CMS clarify that failing data validation requirements constitutes not meeting the requirements of the pay-for-reporting program.

In addition, we ask CMS to clarify the relationship between the pay-for-reporting program and the VBP program. There has been some confusion about CMS' interpretation in the FY 2011 inpatient PPS rule of ACA language around how VBP implementation affects pay-for-reporting penalties. Regardless, we believe that the continued reporting of quality measures on *Hospital Compare* is important for public reporting purposes, even though not all measures will be incorporated into the VBP program.

Third, the ACA excludes hospitals that have been cited by the Secretary of the Department of Health and Human Services (HHS) for deficiencies that pose immediate jeopardy to the health or safety of patients. CMS proposes to define these hospitals as any cited through the Medicare State Survey and Certification process for such deficiencies during the performance period. Before the performance period begins, the AHA suggests CMS take several steps to improve the Medicare State Survey and Certification process. First, CMS should provide additional training for state surveyors. The current survey process in declaring an immediate jeopardy is extremely inconsistent from state to state, which could very well result in systematic biases between areas in the number of hospitals that receive citations and are excluded from the VBP program. Second, we suggest CMS eliminate the ability of state surveyors to cite hospitals for immediate jeopardy regarding issues that occurred previous to the survey, but have since been remedied.

Such retrospective citation is not appropriate. Lastly, we urge CMS to implement a review process by which any immediate jeopardy citations are reviewed by a second level beyond the state surveyor before being made final. As the implications of this citation increase, it accordingly becomes more and more critical that they be made only when appropriate.

Finally, the ACA excludes from the VBP program hospitals with small numbers of applicable patient cases or measures, as defined by the Secretary. For the clinical process measures domain, CMS proposes to exclude from hospitals' scores any measures for which they report fewer than 10 cases and exclude any hospital with fewer than four applicable measures. According to the proposed rule, CMS contracted for an independent analysis to be conducted to determine the minimum number of cases per measure and the minimum number of measures per hospital required to derive reliable performance scores. **We urge CMS to make public the results of this analysis so that all stakeholders may evaluate the results of the study.**

In the absence of data from CMS' evaluation, the AHA believes the proposed case minimum is too low. Currently, the *Hospital Compare* website does not display hospitals' data on a particular measure if they have extremely few cases, which is defined as fewer than 25 qualifying cases, not 10 cases as CMS proposes for VBP. With less than that number, the site states that CMS cannot "be sure how well a hospital is performing." As stated above, given the existence and introduction of so many overlapping and nuanced payment programs in the inpatient PPS, consistency is of paramount importance. Exceptions should only be made when necessary to prevent distortion of payment incentives, which is not the case here. **Thus, we urge CMS to exclude from hospitals' scores any measures for which they report fewer than 25 cases, rather than 10 cases.**

In addition, the agency proposes to also exclude from the VBP program any hospitals for which fewer than four of the 17 proposed clinical process measures apply. **In conjunction with our recommendation above to increase the case minimum, we support CMS' proposal on the measure minimum.** For the HCAHPS domain, CMS proposes to exclude from the VBP program any hospital that reports fewer than 100 HCAHPS surveys during the performance period. **We support CMS' proposed minimum for HCAHPS surveys.**

For hospitals that have data for the performance period, but not for the baseline period, for example if hospitals were not open or did not participate in the pay-for-reporting program during the baseline period), CMS proposes to include them in the VBP program, but only evaluate them on achievement – not on improvement. **The AHA supports this proposal, except for new hospitals.** It will take new hospitals time to become acclimated to all their quality processes, as well as to the pay-for-reporting program. Because of this, we believe it is extremely important for them to have the opportunity to be evaluated on improvement during the first few years of their existence, and not only on achievement as CMS proposes. **Thus, we urge CMS to exclude new hospitals from the VBP program until they have data for both the baseline and performance period.**

In addition, we ask CMS to clarify that its proposed policy applies to any and all hospitals (except new hospitals) that do not have data for the baseline period, including those that do

not meet the minimums in the baseline period and those that failed the data validation requirements of the pay-for-reporting program

The ACA established two demonstration programs for certain hospitals excluded from the VBP program: for CAHs and for hospitals with an insufficient number of patient cases or applicable measures. The demonstration programs, which also are budget neutral, must begin by March 23, 2012 and will run for a three-year period. Although CMS did not make proposals around these demonstrations, in considering their design, we encourage the agency to allow as many hospitals as possible to participate. We also encourage the agency to set broad parameters to allow a wide variety of hospitals to participate, including those of varying sizes.

THE EXCHANGE FUNCTION

CMS proposes to translate each hospital's total performance score into an incentive payment using a simple linear scale, or exchange function. Although CMS considered several types of scales, it states that the linear scale was the most simple and provides all hospitals with the same marginal incentive to continually improve. While CMS proposes that all hospitals with scores above zero receive an incentive payment, it did not specify the exact linear scale it will use to translate a hospital's performance score into its incentive payment. The agency also did not specify what the maximum incentive payment will be or what performance score will be necessary to receive the maximum incentive payment. Such information will need to be calibrated to maintain the budget neutrality of the program.

We analyzed the implications of this linear scale, as well as other types of scales. Because the VBP program is budget neutral, in general, the main characteristic of non-linear scales is that they more aggressively reward hospitals at either the lower end or the higher end of the scale. A scale that more aggressively rewards lower-performing hospitals may provide these hospitals with the resources needed to improve their performance; however, it may not adequately reward hospitals that have already achieved high levels of performance. In contrast, a scale that more aggressively rewards higher-performing hospitals may adequately reward these hospitals, but may not provide lower-performing hospitals with the resources they need to improve. **A linear scale is a balance between these two options and is aligned with AHA's long-standing position that VBP should reward providers for both demonstrating excellence in and improving quality and patient safety. Thus, we support the use of a linear exchange function.**

Similarly, CMS' proposal that the "intercept" of the linear scale be at zero is in keeping with this long-standing position because it means that all hospitals with total performance scores above zero will receive a VBP incentive payment. **Thus, we also support the agency's proposal that the exchange function have an intercept of zero.**

CMS did not make any proposals around how the incentive payments will be made (e.g., as discharge add-ons or a lump sum). We urge the agency to consider that the VBP program represents a substantial change in how hospitals will be paid under the Medicare program. The

manner in which the VBP incentives are distributed will have a substantial 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. 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 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 within 3 months of 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.

PROPOSED HOSPITAL NOTIFICATION AND REVIEW PROCEDURES

The ACA requires CMS to notify hospitals of the performance scores that will be used to determine their VBP incentive payment at least 60 days before FY 2013 begins, or by August 2, 2012. Because CMS proposes a nine-month performance period (as opposed to six months or less), the performance period would end only six months prior to the beginning of FY 2013, and CMS will not have final performance scores by August 2, 2012. Therefore, the agency proposes to inform each hospital through its QualityNet account of its *estimated* incentive payment by August 2, 2012. CMS would then inform each hospital of its *actual* incentive payment for FY 2013 on November 1, 2012.

We support CMS' proposals for notifying hospitals of their estimated and actual incentive payments for FY 2013. While we would prefer that the agency notify hospitals of their actual incentive payments prior to the start of the fiscal year, we appreciate that doing so would necessitate a shorter and/or less recent performance period. However, we suggest that CMS monitor whether notifying hospitals of their incentive payments after the start of the fiscal year creates planning and budgeting challenges; if so, the agency should consider changing the baseline and performance periods accordingly.

In addition, CMS states that it expects to incorporate the VBP incentive payment adjustments into its claims processing system in January 2013, which will allow the adjustment to be applied to FY 2013 discharges, including those that have occurred beginning on October 1, 2012. We

ask that CMS clarify how it will apply this claims processing system change to inpatient discharges retroactively, and whether doing so has implications for the manner in which the agency will make the VBP incentive payments. As noted above, we recommend that CMS distribute VBP incentive payments using a lump sum approach. Accordingly, it should ensure that the manner in which it incorporates the VBP incentive payment adjustment into the claims processing system is compatible with this distribution method.

The ACA requires CMS to establish an appeals process through which hospitals may seek reconsideration of the calculation of their performance assessment with respect to the performance standards and their performance score. CMS plans to propose such a process in future rulemaking. We believe the establishment of such an appeals process should be a priority for CMS, and we suggest that the agency develop and propose such a process prior to FY 2012.

PROPOSED FY 2013 VALIDATION REQUIREMENTS FOR HOSPITAL VBP

CMS proposes to apply the existing Medicare pay-for-reporting program data validation process for both the pay-for-reporting and VBP programs. Under this process, 800 hospitals are selected each year and asked to submit approximately 50 medical records for data validation. The AHA believes that it is appropriate for the pay-for-reporting and VBP programs to rely on the same data validation process. We look forward to reviewing any future refinements to the validation process that CMS proposes in future rulemaking.

QUALITY IMPROVEMENT ORGANIZATION (QIO) QUALITY DATA ACCESS

In the VBP proposed rule, CMS proposes to change the QIO regulations to give itself access to QIO information, including patient and provider-specific information. **The AHA is extremely concerned that the changes CMS proposes to make with regard to access to QIO information strip many of the confidentiality safeguards and go against Congress' original intent in putting the confidentiality provisions in place.**

Section 1160 of the *Social Security Act* protects the confidentiality of QIO information requiring QIO information to be held in confidence by the QIO and makes clear that QIO information is not subject to the *Freedom of Information Act*. CMS published regulations implementing the obligations to protect the confidentiality of QIO information, including the specific stipulation that CMS itself is not privy to certain QIO information.

The current protections instituted around QIO information have encouraged hospital participation in QIO programs, exactly the effect that was intended when the law and implementing regulations were written. The purpose of the QIO program, authorized under section 1862(g) and Part B of title XI of the *Social Security Act*, is to promote the effectiveness,

Donald M. Berwick, M.D., M.P.P.

March 1, 2010

Page 20 of 20

efficiency, economy and quality of care delivered to Medicare beneficiaries. Hospitals under the QIO program take part in a number of quality improvement projects, such as improving patients' transitions from the hospital to post-acute care settings. The QIOs also are instrumental in collecting, processing and maintaining data associated with the Medicare pay-for-reporting program, that is, the data that will be used as the basis for the VBP program.

We are concerned that CMS' proposed changes would make QIO information subject to the *Freedom of Information Act*, and release patient and provider-specific information much more broadly than Congress intended. These changes would undermine the trust that hospitals have in the QIO program and could lead a hospital to withdraw from participating in QIO activities. **The AHA strongly urges CMS not to make the proposed changes to the QIO regulations.**

CMS also requests comments on whether confidential QIO information should be made available to researchers. As we stated above, this would undermine the QIO program and could drive hospitals to cease participating in QIO activities. **We urge CMS not to allow the disclosure of QIO information to researchers.**

If you have any questions, please feel free to contact me or Beth Feldpush or Joanna Hiatt Kim, senior associate directors for policy, at (202) 626-2963 and (202) 626-2340 or bfeldpush@aha.org and jkim@aha.org, respectively.

Sincerely,

Rick Pollack
Executive Vice President