Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

March 8, 2011

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.
Washington, DC 20201

File code: **CMS-3239-P**

RE**: Medicare Program; Hospital Inpatient Value-Based Purchasing Program**

Dear Dr. Berwick:

On behalf of the Catholic Health Association of the United States, the national leadership organization of the Catholic health ministry, representing the largest group of not-for-profit providers of health care services in the nation, I would like to offer the following comments on the referenced notice of proposed rulemaking (NPRM) on a Medicare Hospital Inpatient Value-Based Purchasing (VBP) Program, published in the *Federal Register* (Vol. 76, No. 9, 2454-2491) on January 13, 2011.

The Catholic health ministry is committed to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients. We strive to improve the quality and safety of the care that we provide every day. CHA welcomes the development of a payment system that rewards providers for high-quality patient care, tying quality measurement to performance-based payments in the VBP program. In our support for such a program, we have highlighted two overarching concerns which I would like to reiterate. First, we must always remember, and the program must reflect, that the *goal* of such a payment system must be to improve quality so that patients receive safe and effective care, not to produce federal savings or achieve other secondary goals. Second, great care must be taken to ensure that a VBP system does not decrease access to care for the uninsured or vulnerable populations or disadvantage the hospitals that disproportionally serve them. CMS should monitor the program carefully to identify and address any such unintended consequences.

Proposed Performance Period

Given the implementation time-line requirements of *The Patient Protection and Affordable Care Act of 2010 (ACA)*, in the first year of the program CMS proposes a nine-month baseline period and a nine-month performance period for the clinical process of care and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experiences of care measures. The baseline period would run from July 1, 2009 through March 31, 2010, and the performance period would cover the same three quarters in 2011-2012. **CHA supports the proposal to use nine-month periods for the fiscal year (FY) 2013 baseline and performance periods, and to use the same three quarter time frames for the two periods.** CMS has indicated it expects to propose full-year time performance periods in the future. **CHA urges CMS to use twelve month baseline and performance periods for future years of the VBP program.**

CMS proposes to include the three currently publicly-reported 30-day mortality claim-based outcome measures (MORT-30-AMI (Acute Myocardial Infarction), MORT-30-HF (Heart Failure), and MORT-30-PN (Pneumonia) in the VBP program beginning in FY 2014. For these measures, CMS proposes an 18- month baseline period (July 1, 2008 to December 31, 2009) and performance period (July 1, 2011 to December 31, 2012). A three-year period is currently used for these measures on Hospital Compare. **CHA has concerns about using 18 month periods for the mortality measures.** While CMS adopted the three year period in the quality reporting program to address concerns regarding the reliability of the measures, CMS now says that its analysis shows that eighteen months of these data is also reliable. However, the NPRM does not include the referenced analysis nor is any information provided to confirm CMS' assertion. We also note that an 18-month period could provide confusion and overlap in a VBP program otherwise based on year-long periods. **We urge CMS to maintain the current requirements for the mortality measures until it can provide evidence that an alternative time period would be both reliable and feasible.**

Proposed Measures

FY 2013 Proposed Measures

CMS proposes 17 clinical process of care measures and results from the HCAHPS survey for inclusion in the VBP in FY 2013. The proposed measures are currently in use in the Hospital Inpatient Quality Reporting (IQR) Program and have all been endorsed by the National Quality Forum (NQF) and adopted by the Hospital Quality Alliance (HQA). CHA supports the use of these measures in the VBP. When selecting additional measures for the program, we urge CMS to be guided by the Joint Commission's criteria for measures that are most likely to improve patient health outcomes:

- There is strong evidence that compliance with a given process of care improves health care outcomes;
- The measure accurately assesses whether evidence-based care has been provided;
- The measure addresses a process of care that is in close proximity to the desired patient outcome; and
- The measure is designed to minimize or eliminate unintended adverse effects.

CHA urges CMS to follow the Joint Commissions' accountability framework when selecting future measures for the VBP program, and to adopt only measures approved by the NQF and recommended by stakeholder groups such as the HQA.

The ACA requires CMS to include healthcare-associated infection measures in the VBP program. CMS proposes to categorize four of the Surgical Care Improvement Project (SCIP) measures relating to post-surgical infections as HAI measures for FY 2013. **CHA agrees with CMS' proposal to include these four SCIP measures as HAI measures.**

FY 2014 Proposed Measures

CMS proposes to include in the VBP program eight measures of hospital-acquired conditions (HACs). The enumerated measures are the same measures used in the current HAC policy in the hospital inpatient prospective payment system (IPPS), which prevents additional payment for a case involving a HAC. The same measures will also be used to determine hospital payment penalties beginning in FY 2015 under Section 3008 of the ACA. Thus, hospitals could potentially face duplicative penalties for the same measure. In addition, there are concerns with the accuracy of the measures, which rely on claims data. **Because of issues with the measures themselves and the duplicative use of the measures, CHA opposes the inclusion of the HAC measures in the VBP program, until and unless CMS can address accuracy concerns and ensure that hospitals are not subjected to penalties under multiple policies based on the same measures.**

The ACA requires that the VBP include efficiency measures, including measures of "Medicare spending per beneficiary." While CMS has not made a specific proposal on this topic, it seeks comment. CHA urges **CMS to exclude from the calculation of efficiency measures payment adjustments to the base operating MS-DRG payment amount, such as those for disproportionate share hospitals, indirect medical education, direct graduate medical education, and outlier cases.** These payment adjustments do not reflect increased or decreased provider efficiency but instead acknowledge the willingness of providers to accept the additional costs of providing certain services to groups of patients. **CHA also urges CMS to develop a specific proposal and seek stakeholder feedback on it.**

Future Adoption of Measures

While CMS is proposing the initial measures sets through notice and comment rulemaking, CMS indicates in the NPRM its intent to use a sub-regulatory process to adopt measures in the future instead of going through formal rulemaking. CMS proposes that any measure included in the Hospital IQR program and shown on the Hospital Compare website for one year could be automatically added to the VBP program. CMS indicates it would seek comments on the appropriateness of adopting a given measure for the VBP program, but as the process would be outside formal rulemaking CMS would have no obligation to do so. Similarly, CMS not be required to allow sufficient time for stakeholder comments or to respond publically to issues raised in comments. The reason CMS gives for this proposal is its desire to move the VBP program forward as rapidly as possible. CHA understands the desire to capitalize swiftly on the benefits of linking quality and patient outcomes to payment. However, excluding the public from the measure-adoption process is an inappropriate means to that end**. CHA opposes the proposed sub-regulatory process for adding measures to the VBP program.**

Proposed Methodology for Calculating Total Performance Score

CMS proposes to calculate two scores for each hospital, one for the 17 clinical process of care measures and one for the 8 HCAHPS dimensions. (No information is given on how outcomes will be weighted when they are introduced in FY 2014). To combine these two numbers into a final hospital score, CMS proposes to give 70% weight to the clinical process of care score and 30% weight to the HCAHPS score. CMS appears to have chosen 70% and 30% because the measures and dimensions together total 25 and those percentages represent the approximate proportions of 17 and 8 to 25, respectively. CHA believes a more thorough justification, based on analysis and evaluation, should determine the relative weighting of the domains.

CHA supports the inclusion of patient experience measures in the VBP program. However, we are concerned about achieving an appropriate weighting of the two domain scores. There is evidence from research at the Cleveland Clinic to suggest that a hospital's HCAHPS survey results can be affected by its patient mix. Having sicker patients, patients with longer lengths of stay, and patients with depression symptoms appears to correlate with lower HCAHPS scores. A high weighting of the HCAHPS score may systematically disadvantage hospitals that serve the sickest patients. CHA also urges CMS to evaluate the possible effect of regional variations in HCAHPS results. **Given these concerns, CHA recommends that CMS reduce the weighting of HCAHPS to 20% initially, until further research can be conducted to determine an appropriate population adjustment methodology**.

Another concern with the HCAHPS scoring is the addition of a consistency score. CMS states in the NPMR that it is adding this component to the HCAHPS score to create an incentive to achieve not only excellence in the individual dimensions, but consistent achievement across dimensions. We agree with the goal of across the board excellence. However, CMS gives no reason why it is applying a consistency component to the HCAHPS domain but not the clinical

process of care domain. Nor does CMS explain how this approach will in fact create an increased incentive for hospitals. It appears to add an unnecessary layer of complexity to a new and untested scoring methodology. **CMS should further develop and test the value of adding a consistency element to the methodology before it is included in the VBP program.**

It appears that CMS intends to score HCAHPS using a percentile methodology, which would score hospitals relative to each other. This is a different approach than CMS proposes for calculating clinical process of care scores. **CHA recommends that CMS use a methodology for HCAHPS that relies on the actual score rather than a relative percentile, as it proposes for the process of care calculations.**

Applicability of the VBP Program to Hospitals

The ACA provides that certain hospitals are excluded from the VBP program. One category of excluded hospitals is those subject to a payment reduction for failure to report quality data under the Hospital IQR program. There is some confusion about the relationship between the Hospital IQR and VBP programs. **We request that CMS clarify how the Hospital IQR and VBP programs will operate together.** For example, it would be useful if CMS could confirm that hospitals subject to the quality reporting penalty would not be subject to the VBP reduction.

Hospitals with too few applicable patient cases or measures are also excluded from the VBP program under the ACA. CMS proposes that hospitals will receive clinical process of care scores only for those measures in which they had at least 10 patient cases, and will be included in the VBP program only if they have at least four applicable measures.

CMS commissioned a Brandeis University study to determine the appropriate minimum numbers of cases and measures. The study is cited in the NPRM to justify CMS proposal, but CMS has not made it available to the public. We believe setting the case number minimum at 10 is too low. The current quality reporting program considered fewer than 25 cases per measure insufficient. **In the absence of additional publicly available data and analysis, CHA believes CMS should exclude from a hospital's score any measures for which it has fewer than 25 cases.**

CMS proposes to include in the VBP program hospitals for which there is performance period data but no baseline period data, but to score them only on achievement. We are concerned that new or newly converted hospitals could be negatively affected by this policy. New hospitals will need time to get their quality and repotting processes in place. It is important that they have the opportunity to be evaluated on how much they improve at the beginning of their participation in the VBP program, not just on achievement. **CHA urges CMS to exclude new hospitals with no baseline data from the VBP program.**

Incentive Payments

CMS did not include in the NPRM how it plans to distribute the 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 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.

Thank you for the opportunity to share CHA's comments on the VBP program proposal. We look forward to working with you to continually improve the quality and safety of the services our hospitals provide and the health outcomes of the patients they serve.

Sincerely,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy