Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

March 8, 2011

Donald Berwick, MD, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: 42 CFR Parts 422 and 480: Medicare Program Hospital Inpatient Value-Based Purchasing Program Proposed Rule

Dear Dr. Berwick:

The 29 undersigned consumer, purchaser, and labor organizations appreciate the opportunity to submit comments to CMS on the proposed hospital value-based purchasing (VBP) regulation, as created by Section 3001(a) of the Affordable Care Act (ACA). We firmly believe that value-based purchasing – across all provider settings – can be a powerful tool for transforming the health care system from one that reimburses providers based on the volume of services provided, to one that rewards providers for the overall quality of care delivered.

It is critical that the program foster rapid improvement by being fully transparent, tying payment to high quality performance, and promoting a market that recognizes and rewards quality. Over time, an increased portion of hospitals' payment should be tied to performance on measures that reflect whether patients are receiving care that is consistent with the Institute of Medicine's aims of safe, timely, effective, efficient, equitable, and patient-centered care.

While ACA imposes a number of restrictions on which quality measures are eligible for the VBP program, we urge CMS to push the boundaries of these restrictions and move forward as aggressively as possible to use measures a) where there are clear gaps in hospital performance; and b) that reflect the categories of care that are most meaningful to consumers and purchasers such as, outcomes, functional status, care coordination and transitions, and patient experience.

In addition to our specific comments on the proposed rule, we would like to use this opportunity to note the importance of viewing the hospital VBP program as a critical tool within a comprehensive set of strategies designed to advance quality-based payment models such as accountable care organizations (ACOs), patient-centered medical homes, the Meaningful Use of HIT incentive program, and bundled payment programs. A patient's care does not begin or end in the hospital setting, so it will be critical to align VBP with quality and payment programs targeting other settings across the care continuum. By aligning policies, measures, and methods across programs, CMS can leverage hospital VBP to:

- Promote and encourage care coordination across settings;
- Support the integration and delivery of services for those with chronic illnesses;
- Support re-engineering of care systems in ways that are patient-centered;
- Provide ongoing support for both patients and their caregivers; and
- Encourage the provision of high-quality, efficient and effective care for those who are most vulnerable to and/or already suffering from multiple chronic conditions.

Achieving these goals will require not just alignment among public sector programs, but also strategic cross-fertilization and alignment between the public and private sectors.

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Our comments focus on components of the proposed rule that we support and encourage CMS to retain, as well as recommendations for how the program can accelerate improved care for consumers.

- Proposed Measures for FY 2013, 2014, and Beyond
- The Scoring Methodology for both process measures and HCAHPS
- Public Reporting of Hospitals' Performance Scores
- Suggestions for the Evolution of Hospital VBP

PROPOSED MEASURES FOR FY 2013, 2014, AND BEYOND

FY 2013 Process Measures

Our comments on the proposed FY 2013 measures relate to the concerns expressed above that the CMS needs to move more quickly to implement the measures that will be most meaningful to consumers and purchasers, and to improving overall quality of care in the system. We advocate for speeding implementation of outcome measures, and at the same time reducing the volume of process measures by focusing only on those for which performance has been found to be low across the board:

- **Add three outcome measures in the first year**: We strongly urge CMS to implement hospital VBP as aggressively as possible by including the three mortality measures for AMI, Heart Failure and Pneumonia in FY 2013. This could be achieved by shifting the beginning of the performance period up to April 2011 so that a full 18 months of data are available prior to the program's start date of October 2012. We also encourage CMS to review the statistical method used to risk-adjust the mortality measures, which is controversial within the biostatistician community[1] for a number of reasons, including the fact that it results in lack of differentiation among hospitals.

- **Re-assess and reduce the number of process measures:** The proposed rule explains how CMS looked at the full range of Inpatient Quality Reporting measures and selected those that met the ACA criteria. However, based on Table 3 of the proposed rule which provides data on hospitals' performance across the 17 proposed process measures, it appears that hospitals are already performing at or above 90 percent on most of these processes. Therefore, we do not believe those measures are appropriate for this program, unless the performance benchmark (discussed in more detail below) is raised.[2] We urge CMS to take a closer look at the process measures proposed for FY 2013 to narrow the list of measures by focusing on those where substantial improvement is needed, as well as those processes that are directly linked to improved outcomes. Focusing solely on those where hospitals are not demonstrating high performance will help to achieve the goal of the program – improving overall outcomes for patients and improving value overall for payers and consumers.

HCAHPS

We fully support the inclusion of the HCAHPs measures for FY 2013 and are confident that it is appropriate for use in a pay-for-performance program. HCAHPS adds significantly to our overall understanding of how patients experience their hospital-based care in a way that process measures do not. Hospitals have had to collect and report HCAHPS data since 2002 in order to receive their full Medicare annual payment update, and thus will have over a decade's worth of experience in using this tool by the time the VBP program goes into effect. Furthermore, over two hundred hospitals are participating in private sector pay-for-performance initiatives, such as the Premier QUEST demonstration, that include HCAHPS as part of the scoring methodology for determining a hospital's bonus payment.

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[1] See, for example, Racz, M. J. and J. Sedransk, "Bayesian and Frequentist Methods for Provider Profiling Using Risk-Adjusted Assessments of Medical Outcomes," *J. of the American Statistical Association*, 105:489 (March 2010), 48-58, and Kipnis, P., G. J. Escobar, and D. Draper, "Effect of Choice of Estimation Method on Inter-Hospital Mortality Rate Comparisons," *Medical Care*, 48:5 (May 2010), 458-465.

[2] While measures for which hospitals are already performing at 90 percent or higher may not be appropriate for VBP, we advocate for measures related to important quality processes continue to be reported on Hospital Compare, to ensure that quality in those areas does not decline.

Research shows that hospitals have achieved significant improvements in their HCAHPS results following implementation of certain interventions. For example, the establishment of hourly nursing rounds during which nurses improve and increase communication with the patient has yielded positive effects on HCAHPS scores as well as better clinical outcomes.

Finally, the inclusion of HCAHPS in the hospital VBP program highlights an important opportunity for CMS – in conjunction with the Agency for Healthcare Research and Quality (AHRQ) – to develop additional questions assessing the post-discharge experience, particularly in the areas of care coordination and patient safety/medication management. As efforts ramp up in the public and private sectors to understand the causes and reduce the rates of hospital readmissions, having a better understanding of patient perspectives of their post-hospital discharge experience will help to inform improvements to guide these activities.

FY 2014: Healthcare-Acquired Conditions

We strongly support linking performance payment to patient safety; including the eight hospital-acquired conditions (HACs) in this program will help to advance that goal. The HACs in the proposed rule are widely recognized as serious and preventable via evidence-based best practices. Five of the eight (foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcers III/IV, and falls and trauma with injury) have been endorsed via a multi-stakeholder consensus process as "events appropriate for use in event reporting systems" by the National Quality Forum as part of a larger set of Serious Reportable Events. One of the HACs (manifestations of poor glycemic control) has been recommended through the same NQF process for endorsement as part of a set of Medication Serious Reportable Events. Finally, there are NQF-endorsed measures related to the last two HACs in the proposed rule, related to Catheter-associated UTI and Vascular-Catheter Associated-Infection. In addition, all eight HACs went through a rigorous rulemaking process last year for inclusion in the Medicare Inpatient Public Reporting Program. Including these eight HACs in the hospital VBP program serves to emphasize Medicare's commitment to improving patient safety in the hospital setting, which will have significant effects on patient outcomes as well as on costs to the system as a whole.

Measures for FY 2015 and Beyond

To fill the gaps identified in outcome, functional status, and patient-reported measures – which are critically important to consumers and purchasers for improving inpatient care and reducing costs – we recommend measures and measure concepts for implementation and development over the coming years. Where there are specific measures already available, such as the Potentially Avoidable Complications and nosocomial infection rates, we urge CMS to put these in the inpatient quality reporting pipeline and the Hospital Compare reporting process as rapidly as possible to allow for implementation into hospital VBP by FY 2015. We also offer suggestions in areas where there are no NQF-endorsed measures but that have been identified by the Office of the National Coordinator for HIT (ONC) as critical to improving patient-centered care and for which efforts are being made to speed development to get them into use:

- Potentially Avoidable Complications (PAC) Measures: Three recently NQF-endorsed measures look at the proportion of patients hospitalized with either 1) AMI; 2) stroke; or 3) pneumonia, and who experienced a potentially avoidable complication either during the hospital stay, or in the 30-day Post-Discharge Period. These are extremely important and meaningful measures that can help to improve not only inpatient care, but also care coordination and transitions for three conditions that have been identified as targets for VBP. They are also intuitively to consumers and purchasers.

- Efficiency, Resource Use, and Appropriateness Measures: We encourage CMS to implement a cost-per-discharge measure that can be linked to corresponding quality measures used in the program, following the Dartmouth Atlas model.[3] Doing so will meet the ACA requirement that hospital VBP incorporate efficiency metrics through the collection of data on the cost-of-care per Medicare beneficiary. The end result will be the ability to identify which hospitals are offering the greatest value, based on their cost as viewed within the context of their overall performance. We also urge CMS to take a leadership role in the development of appropriateness of care measures. Conducting certain

[3] www.dartmouthatlas.org

processes – even if they are evidence-based and performed correctly – does not necessarily equate with high value care if those tests or procedures are not considered appropriate. Therefore, it is critical that we have appropriateness of care measures in the VPB program to assess hospital performance and to ensure that payment is linked to this assessment. Ideally, determination of appropriate use would occur through a formal shared decision-making process that combines clinicians' expert judgment with a patient's personal preferences. ***We encourage CMS to incorporate incentives in the VBP program to reward hospitals for engaging in shared decision-making – as reported by the patient – prior to performance of high cost preference-sensitive procedures.***

- Measures Related to Coronary Artery and Heart Disease (CAD and CHD): We urge CMS to expand the number of conditions reflected in the program by FY 2015 to include measures related to coronary artery and coronary heart disease, and to focus on measures related to rates of use of medication, angioplasty, stents, and coronary artery bypass graft (CABG). Treatment of CAD and CHD provide an opportunity for identifying and addressing appropriate use of these procedures, particularly given the high volume and cost of stents, angioplasty and CABG performed, and the high rates of variability in quality and outcomes.

- Hospital-Acquired Infection (HAI) Measures: CMS will add central line-associated blood stream infection (CLABSI) and surgical site infection (SSI) to the Inpatient Quality Reporting program in FY 2013 and 2014, respectively. ***We ask CMS to describe in the final VBP rule the timeline for implementing these measures into hospital value-based purchasing as required by the Affordable Care Act.*** Overall, we urge CMS to move quickly to meet the recommendations outlined in the January 2009 Department of Health and Human Services *Action Plan to Prevent Healthcare-Associated Infections*. The Action Plan lists a number of HAIs for which efforts must be made to significantly reduce occurrence, and the Affordable Care Act requires that the *Action Plan* recommendations be integrated into the hospital VBP program by FY 2013. While we understand this deadline may not be met, we urge CMS to propose a plan for implementing the following *Action Plan* measures in the Inpatient Quality Reporting program so that the stage can be set for introducing them into hospital VBP:

    - Central Line Bundle Compliance
    - Clostridium Difficile 1 and Clostridium Difficile 2
    - Number of symptomatic catheter-associated UTIs per 1,000 urinary catheter days
    - MRSA 1 (incidence rate per 100,000 persons of invasive MRSA infection)
    - MRSA 2 (related to facility-wide healthcare facility-onset MRSA)

  Further, we urge CMS to move forward quickly on establishing action steps to include measures, targets, and payment policies for ventilator associated pneumonia (VAP), as well as for infections that occur primarily in dialysis centers and ambulatory surgical centers (ASCs), categories which are being explored in Tier 2 of the *Action Plan.*

- Measures of Patient-Reported Outcomes and Engagement: We urge CMS to identify additional measures that use patient-reported data to assess experience of care, outcomes, and functional status. Toward that end, we encourage CMS to leverage the collaborative work it is already engaged in with the Office of the National Coordinator for HIT (ONC) in promoting development and/or pushing existing measures into the quality enterprise pipeline. One example of such a measure that we would hope to see endorsed by a multi-stakeholder consensus-based process and ultimately see widely implemented is the Patient Reported Outcomes Measure Information System (PROMIS), which provides clinicians with outcomes data across an array of domains, such as symptoms, functional status, and pain, all from the patient's own reporting of experience. In addition, we urge CMS to explore ways to increase the capacity of HCAHPS to collect patient-reported data on care coordination and transitions, as well as on adverse events. This should include leveraging activity currently underway at AHRQ to conduct focus groups with consumers about medical harm events for the purposes of expanding the HCAHPS tool.

- Cross-Cutting Measures of Care for Patients with Multiple Chronic Conditions: Measures of care coordination and transitions, resource use, and appropriateness that cut *across* conditions are critically needed to determine how well care is being provided to patients with multiple chronic conditions. For the VBP program to evolve and mature, we urge CMS to take a leadership role in tying payment to measures that will address the needs of the highest-cost and most vulnerable populations within our system.

Use of Sub-Regulatory Process to Add Measures

Since CMS is required by the Affordable Care Act to select measures for the hospital VBP program from the pool of measures already in use in the Inpatient Quality Reporting Program, this means that these measures will have already been subject to a rigorous federal regulatory process with ample opportunity for public comment. Thus, we fully support use of a sub-regulatory process to expand the set of measures to the HVBP program.

SCORING METHODOLOGY

We support the scoring methodology as described in the proposed rule, both for the calculation of improvement scores and achievement scores. At the same time, we encourage CMS to establish an evaluation strategy for monitoring the scoring method and assessing whether it proves to be appropriate or incorporating changes if necessary to ensure the program achieves its stated goals.

Weighting of Process Measures versus HCAHPS

We urge CMS to amend the proposed weighting structure for the scoring methodology by increasing the weight attributed to HCAHPS to 40 percent of the score, and reducing the weight assigned to process measures to 60 percent. We also recommend that when outcome measures are implemented, that they displace a portion of the process measures' weight. ***As noted earlier, we believe patient experience is a critically important dimension of quality, and as such, must remain a significant indicator of overall hospital performance.***

Establishment of Threshold and Benchmark Designations

We believe the use of a threshold "floor" which hospitals must attain to receive a ranking on the achievement and improvement scores is appropriate and should be maintained in the scoring equation.

We are also tentatively supportive of setting the benchmark "ceiling" at the median of the top decile of performers. However, as noted earlier, according to Table 3 of the proposed rule it appears that most hospitals already will have met the benchmark, undermining the rigor of the program. Without ample detail in the proposed rule regarding how this benchmark was selected, nor explanation for how the data in Table 3 were calculated, it is difficult to provide productive comments on the benchmark. We urge CMS to explain in further detail how it calculated the benchmark, including what data were used.

In the end, the most critical issue is that the benchmark be set at a level that will motivate hospitals to improve care. Thus, we urge CMS not to view the benchmark separately from the measures, but rather to be flexible in setting the benchmark to ensure it appropriately reflects variation in performance and provides an incentive to improve. These objectives will make the program's results more consequential. We also suggest calculating what the effects would be if the benchmark across all process measures was raised, or, conversely, setting a different benchmark for different measures, to reflect the existing differences in performance.

Finally, on the methodology for determining hospitals' HCAHPS scores, we support the concept of adding a consistency score to provide hospitals with additional credit for having consistently high scores across all the HCAHPS measures.

PUBLIC REPORTING OF HOSPITALS' PERFORMANCE SCORES

ACA requires that information on individual hospital's performance in the VBP program be reported on *Hospital Compare,* including performance on each measure for which they are scored, composite performance on each condition/procedure and patient experience, and finally, on overall score. We believe that, when displayed appropriately, this information will represent a tremendous improvement over what is currently available to consumers and purchasers. The challenge, of course, is determining

how to display the data appropriately. ***We appreciate and support the current efforts at CMS to improve the data display of measures that are part of the inpatient and outpatient quality reporting programs, and believe that these types of activities should be ongoing and apply to the measures that are used in hospital VBP as well.***

There are significant differences between pay-for-reporting and pay-for-performance, so hospital ratings for public reporting displays should be determined separately from the scoring that is used for performance-based payments. We understand that payment is intended to affect provider behavior, not consumer behavior, and requires more precise estimates of performance. Research indicates that consumers have a higher tolerance for uncertainty in provider ratings, but at the same time want information displayed in a way that makes intuitive sense and is meaningful. For example, display of outcome measures that utilize risk adjustment methods must be presented in a way that shows meaningful differences in provider performance, rather than grouping almost all providers in the "no different than the national average" category. ***We urge CMS to use the opportunity provided by the implementation of hospital VBP to continue to address issues of data display on Hospital Compare and work with consumers and purchasers on how the important measures that will be used in the program can be displayed to promote frequent use of information by consumers.***

As part of this assessment, we urge CMS to <u>continue developing composite measures for public reporting</u>. Composite scores reduce the cognitive burden for users by integrating complex information into a single score. We urge CMS to use all-payer data in the calculation of these composites, rather than just Medicare data. Alignment of incentives to provide high quality care across both the public and private sector payers should be deeply ingrained into the program. In that regard, we urge CMS to change Quality Improvement Organization (QIO) regulations to allow greater flexibility to access QIO data than is now permitted. This step will allow for the kind of all-payer data public reporting that we support.

Beyond the data display of performance measures, we support the provision in the ACA that would allow for Hospital Compare to also <u>report an aggregate of which hospitals received payments for high performance and which hospitals lost payment for poor performance</u>. The proposed rule does not address how this level of reporting would occur, but we urge CMS to implement this provision. We support all efforts at CMS to promote transparency, and feel that having this aggregate information is an important component to the public reporting piece of this program.

Finally, as we have advocated in the past in our comments to CMS on the inpatient and outpatient pay-for-reporting programs, we continue to urge that hospital performance in the VBP program be <u>reported at the distinct individual hospital level</u>. Currently, reporting is done based on an institution's CMS Certification Number (CCN), which may be the same for multiple hospitals that share common ownership, operate under a single license, and report to Medicare as a single entity. While this may be practical for data collection purposes, it does not facilitate performance improvement or help beneficiaries make choices between hospitals.

<u>HVBP FUTURE CONSIDERATIONS</u>

We hope that this program will evolve to reflect both the new initiatives and policies in the ACA and the ongoing needs of consumers and purchasers. Consumers and purchasers are clamoring for information not just across care settings, but on <u>variations in care *within* settings</u>. For example, we know that performance can vary dramatically not just across hospitals but also within hospital departments. We urge CMS to develop incentives that are based at the service-line level for specific clinical areas as well as hospital-wide.

In regard to the scoring methodology, we suggest that CMS consider the possibility of adding an element to the score that reflects whether hospitals provided all the evidence-based care for particular <u>episodes</u> of care via an "all-or-nothing" score. This would likely require defining a number of conditions and assigning measures that have evidence linking them to positive outcomes to each of these episodes. We believe this would align with the current investment CMS is making in the creation of Medicare episode grouper methods.

Finally, we continue to urge CMS to accelerate its efforts to develop systems that can accept quality metric data that are collected, aggregated and submitted to CMS electronically, either through registries or via meaningful use requirements that align with VBP measures. Several strategies exist to improve the efficiency of data flow, and should be incorporated into the implementation of this program. These include reducing or eliminating duplicative algorithm programming by multiple vendors through the use of a common code, which could be achieved by a collaboration among CMS, the Joint Commission, and the various Performance Measurement System vendors working in this space currently.

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the VBP program. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely,

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AFL-CIO
American Benefits Council
American Federation of State, County & Municipal Employees
American Hospice Foundation
The Buyers Health Care Action Group
Consumers' CHECKBOOK
Childbirth Connection
Consumers' Union
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