April 19, 2007

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RE: Medicare Hospital Value-Based Purchasing Options Paper

Dear Ms. Phillips:

The twenty-two undersigned organizations representing consumer, labor and purchaser interests appreciate the opportunity to comment on the approach that the Centers for Medicare & Medicaid Services (CMS) has outlined in the Hospital Value-Based Purchasing Options Paper. Incentives should support the evolution of the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. We applaud CMS' leadership in implementing policies that will advance the health care system toward this goal. The comments that follow are based on our common belief that the value-based purchasing elements described in the Options Paper reflect a step towards the more fundamental changes needed to reform Medicare's payment policies. However, more is needed to drive the changes that would foster a reimbursement system that:

- Encourages care coordination and supports the integration and delivery of services for those with chronic illnesses;
- Supports the re-engineering of care systems;
- Reduces health care disparities and encourages the provision of quality care for at-risk populations; and
- Recognizes efficient and effective care may reduce expenditures both within a single sector and between sectors (e.g., physician services may reduce expenditures in emergency rooms and hospital care).

We believe that any payment reforms should emphasize incentives for care delivery that promotes these goals, rather than providing all types of care with the same potential rewards for "better performance."

While our comments on the Options Paper are articulated below, we first wanted to voice our support for the goals of the Medicare Value-Based Purchasing Program (VBP), namely that it will:

- Improve clinical quality;
- Address problems of underuse, overuse, and misuse of services;
- Encourage patient-centered care;

- Reduce adverse events and improve patient safety;
- Avoid unnecessary costs in the delivery of care;
- Stimulate investments in structural components and the re-engineering of care processes system-wide;
- Make performance results transparent to and useable by consumers; and
- Avoid creating additional disparities in health care and work to reduce existing disparities.

Further, we applaud several of the assumptions that underpin the Value-Based Purchasing Program, in particular that it will:

- Start no later than Fiscal Year 2009 (October 1, 2008);
- Require hospitals to submit data on all measures applicable to their patient population and service mix;
- Reward hospitals that improve their quality performance as well as those that achieve high level of performance;
- Rapidly expand the measures available to assess clinical quality, including HCAHPS, efficiency, and hospital outpatient measures; and
- Evaluate the Program's effects, assess for unintended consequences, and adjust the design based on lessons learned.

Below we provide specific comments on the seven sections of the Options Paper: (1) performance assessment model, (2) translating scores into payment; (3) structuring payments; (4) measures; (5) transitioning to VBP; (6) data submission and validation infrastructure; and (7) public reporting of performance results.

PERFORMANCE ASSESSMENT MODEL

We applaud the structure of the Performance Assessment Model because it can accommodate a rapidly expanding and varied set of performance measures. Further, the model rewards hospitals based on attaining benchmark performance or improvement so it has the potential to "raise all boats."

Further, we support basing a hospital's performance score on the measures for which it can report given its patient population. This approach allows for flexibility to account for a hospital's service mix. However, as more measures are incorporated into VBP, CMS should consider allowing the model to recognize and adjust the incentive to take into account the number of measures reported. For example, as the model is currently structured it does not differentiate between a hospital attaining 100% on two measures versus seventeen measures.

TRANSLATION OF SCORE INTO INCENTIVE PAYMENT

There are three variables that can be altered to translate a hospital's performance score into an incentive payment: (1) minimum performance level; (2) benchmark performance level; and (3) exchange rate. We believe that CMS should set the minimum performance level so that hospitals strive to attain the required performance level before qualifying for an incentive payment. For those hospitals whose performance falls between the minimum and the benchmark performance level, the exchange rate is responsible for translating the score into the percent of the incentive payment earned. We believe that a 1:1 exchange rate is both intuitive and equitable.

OPTION FOR STRUCTURING INCENTIVE PAYMENTS

We support CMS' proposal that the incentive be a percentage of the DRG payment and that the percentage be established annually. This approach is preferred as it divorces payment from the size of annual payment update, which could be zero or negative in some years.

The share of payment tied to performance should be substantial. We believe that initially the performance incentive for hospitals should be on the same order of magnitude as the level of incentive that rewards public reporting, which was 2% of total Medicare payments. To that end, CMS should, at a minimum, go beyond the base DRG payment only and include capital costs when establishing the basis for quality incentives. Further, incentives should be applied to all payments, not to a subset of DRG codes.

Since not all hospitals will earn the full incentive payment, a pool of unearned funds will be generated. We believe that these funds should be set aside and directed to measure development, testing, and endorsement in order to fill critical gaps and address the full spectrum of care (see below for details on measure development parameters).

VBP MEASURES

The measure selection criteria outlined on page 21 should be revised so that "Controllability" is changed to "Ability to Influence" to clarify that measures should be associated with practices that a provider can influence or impact. [This suggested language mirrors the AQA Parameters for Selecting Measures for Physician Performance v. 3, revised April 2006.]

We affirm the need for measures and payment to support the provision of care that is high quality, patient-centered, efficient, and equitable (e.g., reducing disparities in health care). In order to address the full spectrum of care and the multiple dimensions of quality, we strongly support the rapid inclusion of efficiency, outcome, outpatient (e.g., emergency care and ambulatory surgery), care coordination, patient safety, and structural measures for FY 2010, as noted in Table 3, page 24. We also strongly support the development of measures to assess equity. It is important to note that the development of these measures is aligned with supporting the goals of the VBP Program outlined on page 3.

The Federal Government should work with private funders to support the development and endorsement of a robust set of hospital performance measures. Specifically, we recommend the following actions:

- HHS, CMS, and/or AHRQ should provide substantial and ongoing funding to support development of consumer-relevant measures that fill existing gaps (especially clinical outcomes, efficiency, patient-centered/continuum of care, and equity). Developing measures is a public good that requires significant financing from the public sector. Today we have a critical need for well-specified and endorsed measures that meet consumers' and purchasers' needs. The federal government should specifically support the rapid development of measures that are:
 - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound and evidence-based, but are not held to unrealistically high academic standards such that good and useful information is delayed.
 - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed are currently available in electronic form or can be collected with limited reporting burden.
 - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must be a significant factor in the development of measures.
 - Reflect the continuum of care/care coordination from a patient's perspective.
 Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.
 - Address appropriateness of care. Measures are needed to assess whether or not the care provided to the patient was needed and whether patients got the

needed care (e.g., measures of overuse of treatment of services should complement measures of underuse).

 HHS or CMS should provide core ongoing operating support for the National Quality Forum (NQF) to ensure ongoing, independent consensus process reviews, endorsements, and updates of measures to enable the availability of comparative information and the reduction of provider reporting burden.

We are pleased that CMS will continue to work collaboratively with consensus organizations (e.g., the National Quality Forum) and other stakeholders such as the Hospital Quality Alliance, Joint Commission and others to address issues stifling the measurement "pipeline."

As noted in the Options Paper, some hospitals may have too few cases for certain measures to produce a stable estimate of performance. We applaud CMS for trying to address this issue and broaden the pool of participating hospitals. Strategies that could facilitate this goal should be explored further, e.g., rolling up data over multiple time periods, Bayesian methodology. CMS should also closely evaluate the exclusionary criteria hospitals are applying to measures to ensure that it does not exacerbate the problem. In addition, this issue would be mitigated if additional "cross-cutting measures" that are relevant to the majority of patients are developed in the near future.

TRANSITIONING TO VALUE BASED PURCHASING

We strongly believe that CMS should aggressively pursue value-based payment. Hospitals and CMS both have had years of experience with the measures in question and, therefore, are well positioned to move forward rapidly.

DATA SUBMISSION & VALIDATION INFRASTRUCTURE

Given its increasing relevance in the marketplace, accurate, and complete data is absolutely critical, particularly so that stakeholders can trust the credibility of the information. As CMS continues to enhance the accuracy of the information posted on the Hospital Compare website, the methodology adopted should be fully transparent to allow all stakeholders to clearly assess hospital-level reliability. We believe that the proposed modifications to the existing data infrastructure will improve the accuracy and timeliness of data used for making payment determinations and public reporting. The changes minimize the time associated with data submission and validation and would allow the financial incentives to more closely reflect a hospital's performance. We also encourage CMS to review the benefits of closely aligning their data submission timetable with that used by a number of states.

We support CMS's suggested methodology to assess the accuracy of measure calculation and to minimize the likelihood of gaming among hospitals. The appropriate use of denominator exclusions should also be assessed and hospitals should be made aware that excess use of exclusions could result in penalties. Going forward, as the percentage of payment at risk increases, CMS must dedicate the necessary resources to ensure adequate oversight so that all stakeholders have confidence in the quality, validity, and accuracy of the data.

PUBLIC REPORTING

The scoring and the display of performance information should be made, first and foremost, with consumer decision-making in mind. We support CMS in its efforts to ensure that performance information is accessible and "evaluable" by the consumer.

To that end, CMS should continue to allow private-sector organizations to have full access to provider performance information (numerator and denominator) from the Compare websites. Many plans rely heavily on the all-payer data to populate their provider selection tools and

without access to granular performance data could impose additional reporting requirements on providers.

We urge CMS to improve the utility of the Hospital Compare website by implementing the following strategies:

- Report hospital performance at the most granular level possible (i.e., at the individual hospital level versus aggregated across multiple campuses and at the condition or service-line level within hospital). Consumers need information at this level to inform their decisions.
- Allow consumers to sort hospitals by performance as well as other key characteristics.
- Show meaningful differences in provider performance, instead of valuing more highly the risks of misclassification over the risks of not identifying highly likely differences in performance.
- Move rapidly to display composite scores on Hospital Compare. The development of
 composite scores is critical to help consumers integrate complex information into their
 decision making, though CMS should continue to allow users to "drill down" to a granular
 level of performance detail. Options for constructing composites could include a total,
 overall score combining clinical quality, patient experience, and efficiency; a score on
 each of those three respective domains, and a composite by service line, such as
 diabetes, cardiac care, etc.
- Make an indication of the uncertainty associated with performance such as confidence intervals available to those that have a particular level of interest in the details and operational specifics. It should not be the first level of information available to consumers (for an example, please refer to www.calhospitalcompare.org).
- Suppress performance scores for those hospitals without an adequate number of patients to generate scientifically valid results.
- Highlight hospitals whose data fails validation.
- Provide a consumer with the current picture of a hospital's performance, trending performance is secondary, especially when measures are "topped out." Again, this should be available as "drill down" information.

Finally, we encourage CMS to evaluate the impact of public reporting and value-based payment on quality, cost, access, and disparities.

Thank you for the opportunity to comment on these proposed rules and for your leadership in this important area. If you have any questions, please contact either of the Disclosure Project's co-chairs, Peter Lee, CEO of the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

Center for Medical Consumers
Childbirth Connection
Consumers Union
Employer Health Care Alliance Cooperative
Florida Health Care Coalition
Health Policy Corporation of Iowa
Healthcare21 Business Coalition
Iowa Health Buyers Alliance
Las Vegas Health Services Coalition
Labor Management Health Care Coalition, Upper Midwest
Midwest Business Group on Health

Motorola
National Business Group on Health
National Consumers League
National Partnership for Women & Families
National Small Business Association
National Retail Federation
New Jersey Healthcare Quality Institute
Pacific Business Group on Health
Service Employees International Union

Southwest Michigan Healthcare Coalition St. Louis Area Business Health Coalition