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March 7, 2011

Donald Berwick, M.D.

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Hubert H. Humphrey Building

200 Independence Avenue, S.W., Room 445-G

Washington, D.C. 20201

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 200 member hospitals and health care systems, the Illinois Hospital Association (IHA) is privileged to formally comment on the proposed rule establishing a Value-Based Purchasing (VBP) system for hospitals. We appreciate this opportunity and present the following comments for consideration:

PROPOSED PERFORMANCE PERIOD:

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. IHA does not support inclusion of the mortality measures in the VBP program for FY2014. Additionally, IHA remains 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, which 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. **IHA urges CMS to fully recognize hospitals' improvements and achievements by implementing 12-month (nine-month for FY2013) performance and baseline periods for all measures included in the VBP program.**

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PROPOSED MEASURES:

No measurement should be included in VBP that poses double jeopardy for hospital payments. IHA believes that CMS should limit measurements to one payment program and not include them in multiple payment programs. This recommendation specifically addresses concerns about the inclusion of hospital-acquired conditions in the second measurement round of VBP that already have payment reductions associated with them as the result of prior administrative rule-making processes.

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. IHA agrees that these statistical tests have the potential to identify measures for which it would be extremely difficult to pinpoint any meaningful differences among hospitals’ performance. However, specific measures such as Aspirin at Discharge, Evaluation of LVS Function and Antibiotic Selection for Surgical Patients indicate threshold and benchmark scores that are very close together. For these measures, the national median threshold score is 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 (i.e., the threshold) would receive one point for achievement, while a hospital scoring 0.99 (i.e., the benchmark) or higher would receive 10 points for achievement. However, there is no way for a hospital to score any number of points between 1 and 10 on the achievement range. This seems contradictory to CMS’ intent to exclude topped out measures.

If the goal of VBP is to encourage hospitals via incentives to provide a high level of service and to be compliant with measurements that critically affect the care outcomes, then CMS should include those measurements for VBP. While CMS is proposing to eliminate measurements in which the scores are “topped out,” IHA believes these measurements should continue to be included if they are key to positive outcomes of care. If hospitals are all providing care at a top level, this is something that should be rewarded in any incentive program. Secondly, while CMS has opted to steer clear of weighting process measurements, there is concern that some measurements are vital to positive outcomes of care and others have little or no effect on patient care outcomes.

CMS currently modifies measure specifications through a sub-regulatory process by updating the measure specifications manual twice yearly to reflect changes in science, clinical practice or coding / administrative updates. IHA believes this process is appropriate and should continue. However, CMS is requested 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 clearly articulate its policy with regards to calculating improvement scores when a measure, and possibly a hospital’s general performance on that measure, changes from one year to the next.

PROPOSED PERFORMANCE STANDARDS:

CMS proposes to establish the threshold for achievement of clinical process measures 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. Consequently, this would place the benchmark at or near 100% for 16 of the 17 clinical process measures. Asking hospitals to strive for 100% compliance on these measures may promote the provision of treatment for some patients who may not benefit from it. In addition, asking hospitals to focus resources toward the challenging task of trying to improve their scores on a particular measure from 99% to 100% redirects those resources from other quality improvement projects that may have more clinical relevance.

Because of these challenges, IHA suggests that CMS revise the methodology for calculating the benchmark scores.

The proposed methodology does not evenly reward Achievement and Improvement. Improvement scores tend to be lower and, hence, are less frequently represented in the total VBP score. IHA recommends that CMS establish a separate standard for the Improvement range and not use the Achievement Benchmark as the top end of the range. For example, an Improvement range of x% could be set, then a determination of where each hospital's Performance year score falls between its Baseline period score and that Baseline score + x%. In this way, the Improvement range is the same for each hospital, as is the Performance range.

Per IHA's review of the proposed rule, it appears that the achievement thresholds for most measures will be set at or above 0.90. This is problematic for those hospitals with a small number of patient cases or the minimum number (10) applicable for a particular measure. If such a hospital were to fail on its performance for a measure by just one patient, its achievement score would be unfairly reduced. **Because of this, IHA also urges CMS to revise the methodology for calculating the thresholds.**

PROPOSED METHODOLOGY FOR CALCULATING THE TOTAL PERFORMANCE SCORE:

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. However, IHA believes it is inappropriate to start the scale at *negative* 0.5. For hospitals to improve enough to earn one point, they would first have to "dig" themselves out of this hole of negative points. Hospitals that maintained their baseline period scores or improved by only small amounts should not have negative scores – it is discouraging and could create an inappropriate perception.

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. However, no examples of scoring are given for any of the outcomes measures that CMS proposes to add beginning in FY 2014. Scoring for all of the proposed outcomes measures will be different from that of the clinical process of care measures. For example, the measures relating to the process of care examine care processes that patients should receive. Conversely, 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. **IHA strongly urges CMS to explain in a future proposed rule how it would apply the scoring models to the outcomes measures before adding those measures to the VBP program.**

The process scores are artificially low due to the proposed methodology for setting benchmarks and thresholds. In many cases, the range between the benchmark and the threshold is only a few percentage points, which does not allow for a full range of possible achievement points. For example, a benchmark of 100% and a threshold of 98% allow only four possible achievement scores: 10, 5, 1, or 0. In this scenario, a hospital with a score of 97% would earn no achievement points and likely could earn only minimal improvement points. IHA recommends that CMS: 1) Establish a minimum distance between the Benchmark and Threshold to ensure an adequate Achievement Range or 2) Establish maximum Benchmark and Thresholds (either as percentiles or set scores).

SCORING PATIENT EXPERIENCE OF CARE MEASURES (HCAHPS):

Measurement Selection:

IHA fully appreciates and values the opinions and thoughts of patients on their experience at hospitals and welcomes patients' input. However, those hospitals whose patient treatment rooms are housed in comparatively older buildings may receive lower scores from patients unhappy with their physical environment. For example, these hospitals often face financial limitations when they seek to modernize or renovate their facilities. If one shows a consumer a picture of an older hospital with two beds in a room and a picture of a newer building with one bed in a room and then asks that patient, "Which hospital is cleaner?" the consumer will point to the newer facility with one room. Secondly, older

structures also tend to have centralized nursing stations; consequently, nurses cannot as quickly respond to an individual patient's requests as nurses in nursing station room "clusters" that are found in newer facilities. Increased responsiveness due to facility age and configuration will lead to higher patient satisfaction scores. Therefore, as a result of these proposed measurements, the scores tend to penalize hospitals with older structures which typically are serving economically-challenged communities. Any reductions in payments would widen the gaps in service and support for patients in these communities.

HCAHPS Risk Adjustment Methodology:

- **Mode Adjustment:**

The output scores are still skewed against providers that use telephone and interactive voice recognition (IVR) systems for their survey mode. These hospitals typically serve multi-lingual or low literacy populations, and the use of voice surveys allows the hospital to obtain a representative sample of their entire population. As the mode adjustment can affect the unadjusted scores for hospitals by up to 10%, CMS needs to review this methodology before the HCAHPS scores are utilized. In addition, this mode adjustment is based only upon one study that has not been replicated. In most social science studies, one will find a more accurate and reliable survey result over a previous survey due to the interviewer interaction and the ability to also record the "aside" comments, which are very valuable in highlighting areas of concern by the patient as they apply to the areas being questioned.

- **Patient Mix Adjustment:**

Related to the concerns over the HCAHPS adjustments to the patient scores are concerns over the patient mix adjustments that are applied to each unadjusted score and are **NEW** each quarter. Based upon patient demographic information, each quarter's new adjustments are created based upon patient satisfaction responses and patient demographics. For many providers it is difficult to understand how similar patient demographics and unadjusted responses can result in different adjusted scores from quarter to quarter. For example, a patient who is discharged at the end of a quarter and is surveyed may respond the same way to that survey the next day, which is the beginning of a new quarter for reporting. But because of timing of the responses, the patient mix adjustment varies. IHA believes that it makes no sense to have methodologies change each quarter, requiring the usage and re-running of reports by HCAHPS vendors to adjust for these patient mix adjustments.

Most hospitals will suggest that, for internal improvement purposes, they seldom use the risk adjustment scores except to know about the scores CMS will provide. Hospitals take the face value of what a patient scores for that hospital in the various measurements and bases that on their improvement focus, as opposed to an adjusted score.

The methodology used 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 to the median score for the achievement threshold and to 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. IHA believes that the HCAHPS scoring is overly complex and should be simplified. Converting the raw scores into percentiles or ranks of hospitals may not lead to the same results if that same scoring were done in the same manner as it is for the clinical process measures. The use of percentiles has the unintended consequence of not allowing for a true comparison to baseline period performance (95% is a target number, not a baseline performance level). Thus, **IHA strongly urges CMS to revise 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. Doing so will be simpler, more straightforward and more transparent, which is consistent with CMS' goals for the VBP program.**

CMS also proposes to evaluate hospitals on the consistency of their HCAHPS scores; hospitals could 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 measurements. Specifically, the hospital's lowest score during the performance period would be compared to all hospitals' performances 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 add 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, as there is no rationale in the proposed rule as to why consistency is more important for patient experiences with care measures than clinical process measures. IHA has 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, IHA urges CMS to drop the consistency score from the HCAHPS measures calculations. Instead, the agency should determine a hospital's total HCAHPS points simply by adding the total number of points earned across the eight dimensions and by dividing that number by 80.**

Until there is an examination and public vetting of the scoring methodology of HCAHPS, IHA recommends a suspension of HCAHPS from being included in VBP. **Because CMS seems to be intent on moving ahead with the inclusion of HCAHPS in VBP, IHA urges the agency to reduce the percentage impact to 10% or lower until there is an examination of the HCAHPS measurements, methodologies and scoring by objective parties outside of AHRQ.**

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

No measurement should be included in VBP that poses double jeopardy for hospital payments. IHA believes that CMS should limit measurements to one payment program and not include them in multiple payment programs. This issue specifically addresses concerns of the inclusion of hospital acquired conditions in the second measurement round of VBP that already have payment reductions associated with them as the result of prior administrative rule-making processes.

CMS proposes to combine the scores for the two domains to determine a total performance score. For FY2013, CMS proposes that the clinical process measure domain would account for 70% of the hospital's score and that the HCAHPS domain would account for 30% of the hospital's score. However, IHA is 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 attitudes 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. However, the HCAHPS methodology does not currently adjust for these patient characteristic variables. Consequently, hospitals that care for the sickest patients in the proposed VBP program are disadvantaged.

IHA supports surveying patients on their experiences with care and believes it is an important step in advancing patient-centered care. However, there are 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. IHA urges 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.

APPLICABILITY OF VBP PROGRAM TO HOSPITALS:

Under the ACA, certain hospitals are excluded from the VBP program, including those 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 study 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. However, CMS has not revealed any of the results of this study in the proposed rule. **IHA urges CMS to make public the results so that all stakeholders may evaluate the results of the study.**

In the absence of data from CMS' evaluation, IHA 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 the 10 cases as proposed for VBP. According to that website, CMS cannot "be sure how well a hospital is performing" when a measure is based on less than 25 cases. 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, IHA urges CMS to exclude from hospitals' scores any measures for which they report fewer than 25 cases, as opposed to the 10 cases as proposed.**

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 if a maximum incentive payment would be established, 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.

In the discussion of the 1% of base operating DRG payments that will be available for the VBP program, CMS defines the operating portion as "...total payments using Medicare Part A claims data and subtracted from this number the estimates of payments made as outlier payments (authorized under section 1886(d)(5)(A)), indirect medical education payments (authorized under section 1886(d)(5)(B)), disproportionate share hospital payments (authorized under section 1886(d)(5)(F)), and low-volume hospital adjustment payments (authorized under section 1886(d)(12)). Absent from this definition are Medicare

payments for capital costs. While CMS indicates that it will define the “base operating DRG payment amount” in future rulemaking, **IHA asks that the agency clarify if Medicare capital cost payments will be included or excluded as part of the 1% VBP payment pool.**

There is some question as to how the incentive payments will be made (e.g., as per-discharge add-ons to the DRG payment or through a lump sum payment). IHA urges CMS to consider the magnitude of the Medicare payment changes that the VBP program represents. 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 add a portion of each hospital’s VBP incentive to each of its Medicare discharges, doing so will result in hospitals receiving a very small portion of their overall VBP incentive amount with each Medicare claim. Also, in the past, CMS’ claims processing and payment systems encountered problems that resulted in hospitals’ Medicare claims being suspended or erroneously returned to hospitals for re-submission. When this occurs, hospitals’ payments (including the DRG add-on for VBP) are delayed. IHA suggests that CMS re-think the “add-on” approach, which effectively dilutes any immediate and significant financial effect the VBP program may have on hospital performance. Attaching such small amounts to an already-existing payment could result in those amounts “getting lost” in the overall Medicare reimbursement formula; as a result, this could diminish the significance of the VBP incentive as a reward for a hospital’s high performance.

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. A lump-sum provides every hospital with a monetary measurement of their performance and will create a clearer incentive to improve performance. 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 full, one-time payment to make investments in quality improvement activities within their facilities. **Thus, IHA recommends that CMS estimate each hospital’s VBP incentive based on its projected discharges for the fiscal year and provide a majority of the estimated payment, (i.e., 75%), to the hospital within three months of the beginning of that fiscal year.** The remainder of the payment could be provided during a reconciliation process at the end of the fiscal year in order to maintain the budget neutrality mandated in the statute.

However, if CMS is restricted by statute to paying the VBP incentive as a DRG add-on, for simplicity purposes, CMS should net the VBP pool contribution and incentive payment against each other to develop one adjustment factor to be applied to the base DRG rate and paid out over the course of the year. 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 FY2013 discharges, including those that have occurred beginning on Oct. 1, 2012. **IHA requests that CMS clarify how it will apply this claims processing system change to inpatient discharges retroactively, and**

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whether doing so has implications for the manner in which the agency will make the VBP incentive payments. IHA's concern is that hospitals should not be expected or required to re-submit Medicare claims for those discharges occurring on or after Oct. 1, 2012 through Jan. 2013. Accordingly, CMS should ensure that the manner in which it incorporates the VBP incentive payment adjustment into the claims processing system would place no additional administrative burdens on hospitals.

Dr. Berwick, thank you again for the opportunity to provide these comments. If you or your staff have any questions, please feel free to contact Patricia Merryweather-Arges, Senior Vice-President, Quality, at 630 276-5590 (pmerryweather@ihastaff.org), or Tom Jendro, Senior Director, Finance, at 630 276-5516 (tjendro@ihastaff.org).

Sincerely,

Maryjane A. Wurth
President