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March 8, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Dr. Berwick:

Re: Hospital Value-Based Purchasing Program

On behalf of New York's nearly 200 not-for-profit and public hospitals, the Healthcare Association of New York State (HANYS) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed regulation that would establish a Medicare inpatient hospital value-based purchasing (VBP) program as authorized by Section 3001 of the Affordable Care Act (ACA).

Throughout the development of ACA and the proposed regulation, HANYS has advocated policy principles that would ensure a VBP system that incentivizes improvement of care quality for all patients.

In HANYS believes the Medicare inpatient hospital VBP program must incentivize positive outcomes, hold providers appropriately accountable for using evidence-based practices, and recognize limitations beyond the control of providers. VBP systems must ensure that payment penalties do not result in increases in the inequality of health care delivery—reducing poor performers' resources prevents them from investing in the programs necessary to improve quality. Rather, a VBP system must include the right balance of incentives for both attaining specific quality goals and for demonstrating quality improvement.

HANYS' comments, rooted in extensive data analysis, focus on a number of areas of concern with the proposed rule—policies we believe would not succeed in rewarding appropriately the improved provision of care.

MAIN HEADQUARTERS: One Empire Drive / Rensselaer, New York 12144 / (518) 431-7600 / fax (518) 431-7915 / www.hanys.org
WASHINGTON, D.C. OFFICE: 499 South Capitol Street SW, Suite 405 / Washington, D.C. 20003 / (202) 488-1272 / fax (202) 488-1274

HANYS is pleased to have this opportunity to provide comments on improving the VBP system as described in the proposed rule to better meet the goals of incentivizing improved patient care.

CALCULATION OF IMPROVEMENT SCORES

ACA specifies that VBP performance standards must include levels of both achievement and improvement. It requires that a hospital's performance scores be determined using the higher of its achievement or improvement points for each measure. HANYS has long recommended recognition of both achievement and improvement in the design of the VBP and we are pleased that this important principle was incorporated in the program.

While the performance score will be based on the higher of the achievement or improvement points, it is important that the underlying calculation be calibrated in a manner that achieves the proper balance between the two performance metrics. In comments submitted in response to the CMS October 26 Hospital VBP Program Special Open Door Forum, HANYS reiterated the principles that should govern the design of the VBP program, including the principle that standards for achievement should not be set so high that few hospitals qualify, and improvement standards should serve to motivate, not discourage hospitals striving to achieve better performance.

The VBP system design should provide incentive payments for providers meeting or exceeding the achievement standards but place a high priority on ensuring those with lower scores have the resources and technical assistance to improve. This will provide incentives for all hospitals to work to improve quality of patient care. We believe this is consistent with the policy goals that CMS sets forth in the proposed rule. According to the CMS proposal, *"Our priorities for the Hospital VBP program are to transform how Medicare pays for care and to encourage hospitals to continually improve the quality of care they furnish."*

Further, in discussing the process used to establish performance standards, CMS states that *"We also believe that an essential goal of the Hospital VBP program is to provide incentives to all hospitals to improve the quality of care that they furnish to their patients. In determining what level of hospital performance would be appropriate to select as the performance standards for each measure, we focused on selecting levels that would challenge hospitals to continuously improve or maintain high levels of performance."*

Consistent with CMS' statements, HANYS believes the VBP program should provide quality improvement incentives for all hospitals. To achieve this goal, the methodology should place equal value on both improvement and achievement.

Our analysis of the proposed VBP methodology indicates that improvement is undervalued compared to achievement and the methodology should be modified to achieve a more equal balance between the two.

Analysis of Improvement Scoring

HANYS modeled CMS' proposed VBP methodology using data from the fourth quarter 2009 data release (collection dates: April 1, 2008 - March 31, 2009) as a baseline period; and data from the fourth quarter 2010 data release (collection dates: April 1, 2009 - March 31, 2010) as a performance period.

Distribution of Achievement and Improvement Points

As part of our analysis, HANYS focused on the balance between points awarded for achievement and points awarded for improvement under the proposed VBP.

We examined the results of the proposed VBP scoring methodology for all instances where the hospital improved its score on a measure from the baseline period to the performance period.

The following table shows, for each measure, the number of times the hospital's score on a measure was based on achievement (i.e., the achievement score was higher than the improvement score), the number of times the score was based on improvement (i.e., the improvement score was higher than the achievement score), and the number of times the achievement score was equal to the improvement score.

It also reports the average number of points awarded for improvement and achievement on each measure.

Table 1
Comparison of Points Received for Improvement and Achievement
for Hospitals Whose Scores Increased from the Baseline Period to the Performance Period

Process Measures

Process of Care Domain Measures	Number of Hospitals that Improved	Hospitals Receiving Achievement Points	Hospitals with Equal Achievement and Improvement	Hospitals Receiving Improvement Points	Average Achievement Points Earned	Average Improvement Points Earned
AMI-2	968	466	81	421	10.0	4.8
AMI-7a	14	7	2	5	9.1	4.4
AMI-8a	835	353	105	377	7.9	5.0
HF-1	1759	631	244	884	7.5	3.9
HF-2	1452	579	109	764	10.0	5.0
HF-3	1397	591	133	673	8.6	4.4
PN-2	1914	830	203	881	7.7	4.3
PN-3b	1760	548	247	965	7.8	4.5
PN-6	1716	608	295	813	7.2	4.2
PN-7	1823	792	274	757	7.9	4.6
SCIP-Inf-1	2023	907	325	791	7.9	5.0
SCIP-Inf-2	1251	196	170	885	10.0	4.5
SCIP-Inf-3	2032	852	223	957	7.2	4.6
SCIP-Inf-4	669	236	79	354	7.4	4.2
SCIP-Card-2	1142	249	99	794	6.6	4.8
SCIP-VTE-1	1572	646	197	729	8.0	4.3
SCIP-VTE-2	1664	651	172	841	7.6	4.5

For all process measures, there are similar numbers of hospitals receiving scores based on improvement and on achievement. However, the number of points for the two groups differ significantly. **As the above table shows, the average points awarded for improvement were lower than the average points awarded for achievement on all process measures.**

For example, a total of 1,914 hospitals increased their score on PN-2: Pneumococcal Vaccination from the baseline period to the performance period. When total VBP scores were calculated for those hospitals, the achievement points were higher than the improvement points for 830 hospitals, or 43% of the total. Improvement scores were higher for 881 hospitals, or 46%. Another 203 hospitals (11%) had achievement and improvement scores that were equal. On average, 4.3 points were given to the 881 hospitals that had a VBP score based on improvement. The hospitals whose VBP scores were based on achievement received an average of 7.7 points.

The Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) dimensions show an even greater disparity between improvement and achievement points. For every HCAHPS measure, there are significantly more hospitals with more achievement points than improvement points, and the average improvement points are substantially lower.

Table 2
Comparison of Points Received for Improvement and Achievement for Hospitals Whose Scores Increased from the Baseline Period to the Performance Period

HCAHPS Dimensions

Patient Experience of Care Domain Measures	Number of Hospitals that Improved	Hospitals Receiving Achievement Points	Hospitals with Equal Achievement and Improvement	Hospitals Receiving Improvement Points	Average Achievement Points Earned	Average Improvement Points Earned
Nurse Communication	1179	592	172	415	7.2	2.8
Doctor Communication	1190	625	141	424	6.8	2.7
Cleanliness and Quietness	1047	514	117	416	7.2	2.4
Responsiveness of Staff	1165	575	139	451	7.1	2.5
Pain Management	1330	575	241	514	7.5	3.0
Communication about Medications	1251	594	208	449	7.2	3.0
Discharge Information	1274	658	139	477	7.3	2.6
Overall Rating	1084	552	91	441	7.2	2.6

Uneven Distribution of Improvement Points

Tables 3 and 4 provide more detail on the VBP improvement scoring results for two measures: PN-2: Pneumonia Patient is Assessed and Given Pneumococcal Vaccination (Table 3) and HCAHPS-1: Communication with Nurses (Table 4). These are typical of the results for all of the measures. For those hospitals whose improvement points on the measure were higher than their achievement points, the tables show the distribution of the points awarded for the two metrics. For PN-2, 52% of the hospitals (458 out of 881) with improvement points higher than achievement points had zero points for achievement. Moreover, the number of hospitals with VBP improvement points higher than VBP achievement points consistently decreases as the VBP achievement points increase.

The pattern is even more apparent with the HCAHPS dimension. As Table 4 shows, 61% of (255 of 415) hospitals with more improvement points than achievement points had zero for achievement and the number of hospitals with improvement points than achievement points decreases rapidly as the VBP achievement points increase.

Table 3
Process of Care Measure Example
PN-2: Pneumococcal Vaccination
Distribution for Hospitals Receiving Higher Improvement than Achievement Points

Achievement Points \ Improvement Points	1	2	3	4	5	6	7	8	9	Total	Total %
0	111	85	74	81	59	32	13	3	0	**458**	**52.0%**
1	0	21	15	13	13	5	7	1	0	**75**	**8.5%**
2	0	0	21	15	20	13	8	2	0	**79**	**9.0%**
3	0	0	0	20	20	24	9	7	0	**80**	**9.1%**
4	0	0	0	0	29	15	16	4	0	**64**	**7.3%**
5	0	0	0	0	0	31	23	12	0	**66**	**7.5%**
6	0	0	0	0	0	0	30	24	1	**55**	**6.2%**
8	0	0	0	0	0	0	0	0	4	**4**	**0.5%**
Total	**111**	**106**	**110**	**129**	**141**	**120**	**106**	**53**	**5**	**881**	**100%**

Table 4
Proposed HCAHPS Example
HCAHPS-1: Communication with Nurses
Distribution for Hospitals Receiving Higher Improvement than Achievement Points

Improvement Points → / Achievement Points ↓	1	2	3	4	5	6	7	8	9	Total	Total %
0	129	79	37	10	0	0	0	0	0	**255**	**61. 5%**
1	0	22	31	15	7	0	0	0	0	**75**	**18.1%**
3	0	0	0	12	19	7	0	0	0	**38**	**9.2%**
4	0	0	0	0	19	4	0	0	0	**23**	**5.5%**
6	0	0	0	0	0	0	9	0	0	**9**	**2.2%**
7	0	0	0	0	0	0	0	12	0	**12**	**2.9%**
8	0	0	0	0	0	0	0	0	3	**3**	**0.71%**
Total	**129**	**101**	**68**	**37**	**45**	**11**	**9**	**12**	**3**	**415**	**100%**

This analysis indicates an imbalance between points awarded for improvement and points awarded for achievement. The majority of hospitals that receive a VBP score based on improvement did not qualify for achievement points. When hospitals improve their scores from the baseline period to the performance period and also qualify for achievement points, they are unlikely to receive a VBP score based on the improvement points (i.e., the points awarded for improvement are lower than the points awarded for achievement).

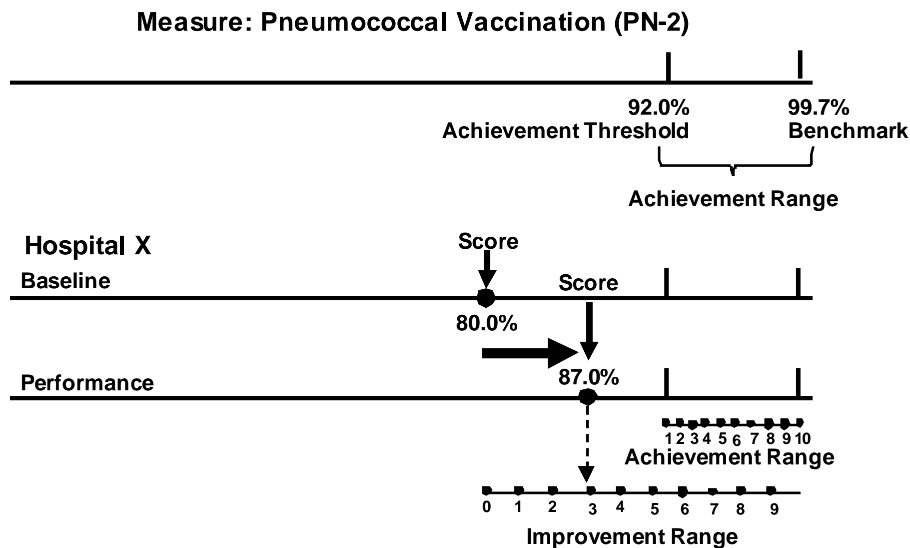
Methodology Issue

The disparity between points awarded for improvement and those awarded for achievement is created in large part by the methodology used in the proposed rule to establish the range for determining VBP improvement points.

In the proposed rule, CMS establishes the following methodology for scoring achievement and improvement:

". . . we propose that hospitals would receive points along an achievement range, which is a scale between the achievement threshold (the minimum level of hospital performance required to receive achievement points) and the benchmark (the mean of the top decile of hospital performance during the baseline period). In determining the improvement score, we propose that hospitals would receive points along an improvement range, which is a scale between the hospital's prior score on the measure during the baseline period and the benchmark."

Under this proposal, CMS sets the achievement threshold at the 50th percentile of hospital performance on the measure during the baseline period. The benchmark for both achievement and improvement would be set at the mean of the top decile of hospital scores on the measure during the baseline period. As a result, if a hospital's score on a measure in the baseline period is lower than the achievement threshold, the marginal increase in points will be less for improvement than for achievement. The following example illustrates this problem.



In this example, the hospital's performance period score of 87% is below the threshold, so the hospital does not receive achievement points. The hospital had a score of 80% in the baseline period and improves by seven percentage points to 87% in the performance period. Therefore, the hospital qualifies for improvement points. The improvement range stretches from 80% to 99.7% (the benchmark) and the hospital would receive three VBP points for a seven percentage point increase in its score.

In contrast, a hospital that qualified for achievement points on this measure would receive significantly more points for the same marginal increase in points. A hospital with a score of 92% in the performance period would receive one VBP point for achievement. A hospital with a score that is seven percentage points higher (e.g. 99%) would receive nine VBP points for achievement. The tighter performance range for achievement awards three times as many points for the same marginal change.

For most process measures, the average improvement from the baseline period to the performance period was in the range of four to ten points. The average improvement for HCAHPS measures was in the range of three to five points. Given the wide scale for improvement points that CMS proposes, improvement of this magnitude will result in very few points awarded to those hospitals whose score in the baseline period is below the threshold.

HANYS urges that the scoring methodology for improvement be revised to provide a more appropriate balance between the improvement and achievement scores. The CMS proposal under-values improvement and fails to provide an adequate incentive to hospitals with relatively low scores that are striving to improve quality of care.

The CMS proposal for improvement scores establishes a linear scale from the hospital's score in the baseline period to the benchmark (based on the mean of the top decile of hospital performance during the baseline period). The proposed scale distributes points proportionately throughout this range so that the interval in performance between the score needed to receive a given number of points and one additional point is the same throughout the range.

One alternative is to set the improvement range between a hospital's score in the baseline period to a benchmark based on the top decile of actual observed hospital improvement between the baseline period and the performance period (instead of a benchmark based on the mean of the top decile of hospital performance during the baseline period). This would calibrate the improvement scale to reasonable expectations of improvement based on actual performance.

As another alternative, the scale for improvement scoring could be calibrated to provide higher points at the low end of the range in place of the proposal, which distributes points proportionately throughout the range. This would provide a strong incentive for those hospitals with relatively low scores in the baseline period to put additional effort into quality improvement.

PATIENTS' EXPERIENCE OF CARE DOMAIN

Patients' Experience of Care Domain Weighting
The ACA requires that the Secretary of Health and Human Services include measures related to the HCAHPS in the federal fiscal year (FFY) 2013 VBP. The ACA also mandates that CMS assign weights to the different categories of quality measures. CMS proposes to weight the patient experience of care domain at 30% of the total VBP score. HANYS fully supports and appreciates the importance of patients' experience of care as a measure of hospital quality of care, but believes that the weight applied to it should be reduced based on the reasons discussed below.

The CMS principles for VBP include: *"To the extent practicable and appropriate, outcomes and patient experience measures should be adjusted for risk or other appropriate patient population or provider characteristics."*

The HCAHPS dimensions are risk-adjusted for age, education, self-rated health status, service line (maternity, medical and surgical), non-English primary language, percentile response order, and age by service line interaction. However, a substantial body of research and evidence indicates that HCAHPS results are subject to individual bias and confounding variables that are not yet accounted for in the methodology.[1]

Research has also found observed patterns within hospitals reflecting differences in patient expectations of care and prior experiences with care among groups of different ethnic compositions.[2] This finding is substantiated by another study investigating racial/ethnic effects on patients' evaluation on primary care services (the Primary Care Assessment Survey).[3]

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[1] Jha, A.H., Orav, E. J., Zheng, J., & Epstein, A.M. (2008) Patients' Perception of Hospital Care in the United States. *N Engl. J Med.* 359(18), 1921-1931.
[2] Goldstein, E., Elliott, M.N., Lehrman, W.G., Hambarsoomian, K., & Giordano, L.A. (2010). Racial/Ethnic Differences in Patients' Perceptions of Inpatient Care Using the HCAHPS Survey. *Medical Care Research and Review.* 67(1), 74-92.
[3] Taira, D.A., Safran, D.G., Seto, T.B., Rogers, W. H., Inui, T.S., et al. (2001). Do Patient Assessments of Primary Care Differ by Patient Ethnicity? *Health Serv. Res.* 36, 1059-1071.

In addition, another study identified significant variation by hospitalization type for five out of the seven HCAHPS dimensions (excluding responsiveness and environment).[4]

Disparities in patient expectations may also contribute to variations in HCAHPS scores between large/urban/teaching hospitals and small/rural/non-teaching hospitals. According to the conceptual model of patient perception of quality, Sofaer and colleagues identified seven factors that influence patients' expectations.[5] Among them, cultural norms, reputation of the entity in question, and the extent of choice available are closely related to the context of HCAHPS score variation between hospitals.

HANYS' analysis confirms other studies showing a strong relationship between hospital bed size and HCAHPS dimension scores. Our modeling (as shown in the table below) of the proposed VBP scores indicates that smaller hospitals (bed size from 0 to 99 beds) have substantially higher HCAHPS domain scores than larger hospitals and there is a consistent decrease in scores as bed size increases. While the reasons for this relationship are unclear, we believe that it relates to the factors identified in the research that tend to result in lower scores for larger hospitals in urban communities with culturally diverse populations.

Bed Size	Overall HCAHPS Domain Score
0 to 49 Beds	58%
50 to 99 Beds	43%
100 to 199 Beds	31%
200 to 299 Beds	25%
300 to 399 Beds	26%
400 to 499 Beds	28%
500+ Beds	24%

Based on the factors discussed above, HANYS recommends that CMS reduce the weight applied to the patient experience of care domain to 10% until adequate risk-adjustment methodologies are developed.

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[4] Elliott, M.N., Kanouse, D.E., Edwards, C.A., & Hilborne, L.H. (2009). Components of Care Vary in Importance for Overall Patient-Reported Experience by Type of Hospitalization. *Medical Care*, 47: 842-849.
[5] Sofaer, S. & Firminger, K. (2005). Patient Perceptions of the Quality of Health Services. *Annu. Rev. Public Health,* 26, 513-559.

HCAHPS Dimension Scoring

CMS proposes *"to score each of the eight HCAHPS dimensions using an approach that parallels the one we are proposing to use to score the clinical process measures . . . ."* While the proposed HCAHPS scoring methodology is similar to the process measure methodology, there is a significant difference. The proposed process domain VBP scores would be determined using hospitals' actual scores on each measure, while the proposed HCAHPS scores would be converted into percentile rankings before calculating the VBP score.

Converting the HCAHPS scores to percentiles is an added and unnecessary step. CMS does not provide any methodological or substantive reason for this conversion. This proposed method adds mathematical complexity but does not yield added accuracy or validity.

The translation of hospitals' scores into percentiles leads to less accuracy in assigning VBP points. Many hospitals achieve the same score on a given HCAHPS dimension. When there are numerous hospitals with the same HCAHPS score, some statistical algorithms would default all scores to the lowest percentile rank; other algorithms would default to the highest percentile. In short, when assigning more than 3,000 hospital scores to 100 percentile rankings, the methodology for breaking ties is problematic.

Finally, hospitals' national percentile rankings are not currently posted on the Hospital Compare Web site. Once the performance year begins, hospitals have no way of tracking their percentile ranking performance—it is not supplied by the HCAHPS vendors. This contradicts the intent of the law, which requires the measures selected for inclusion in VBP to be posted on Hospital Compare for one year prior to the performance period and for hospitals to be able to track their performance.

HANYS urges CMS to calculate the HCAHPS dimensions scores using the same methodology as proposed for the process of care measures. The stated CMS principles for the VBP include: *"Scoring methodologies should be reliable, as straightforward as possible, and stable over time . . . ."* The proposed HCAHPS methodology violates this by adding an unnecessary complication in the use of percentile rankings and by creating different methodologies for HCAHPS and process of care measures.

Consistency Points

Another significant difference between the HCAHPS dimension scoring and the process domain scoring is the addition of a calculation for consistency points. CMS proposes that up to 20 consistency points could be awarded based on the single lowest of a hospital's eight HCAHPS dimension scores.

CMS states that this *"reflects both the interrelated nature of HCAHPS dimensions and the importance of providing incentives to hospitals to improve on each of eight dimensions of patient experience."*

The assignment of 20 points based on the single lowest HCAHPS score puts undue emphasis on a single dimension. A hospital with a single low dimension score could lose up to 30 points out of the 100 points possible for the HCAHPS dimension (ten points for the dimension plus 20 for consistency).

If the intent is to encourage improvement on all eight HCAHPS dimensions, the proposal fails to fulfill this goal. The proposed consistency score acts more as a penalty than as an incentive to improve.

Another factor argues against inclusion of additional consistency points. According to the HCAHPS Web site, the proposed eight HCAHPS dimensions are highly correlated. While the degree of dependence between the responses to different HCAHPS dimensions varies, all are positively related ($p<0.001$) and, and the dependent relationships are not due to chance (i.e., random sampling errors).

This means if a hospital does well on one dimension, it is likely they will do well on all other dimensions; if a hospital does poorly on one dimension, it is likely to do poorly on all dimensions.

A good example would be if a patient responds that nurses "always" communicate well, 60% of times he/she also gives the most positive possible response to the dimension of "Responsiveness of Hospital Staff." Therefore, the proposed consistency points would tend to exacerbate the correlation issue.

HANYS recommends that CMS not include consistency points as part of the patient experience of care domain score. CMS should calculate the patient experience of care domain in the same manner as the process of care domain and not include additional points for consistency.

HCAHPS Patient-Level Correlations*

	Communication with Nurses	Communication with Doctors	Responsiveness of Hosp. Staff	Pain Management	Communication about Medicines	Cleanliness of Hospital Env.	Quietness of Hospital Env.	Discharge Information	Overall Hospital Rating	Recommend the Hospital
Communication with Nurses	1	0.51	0.60	0.58	0.52	0.41	0.35	0.26	0.65	0.58
Communication with Doctors		1	0.37	0.44	0.42	0.26	0.26	0.26	0.47	0.43
Responsiveness of Hosp. Staff			1	0.51	0.43	0.36	0.33	0.21	0.53	0.47
Pain Management				1	0.45	0.33	0.31	0.25	0.55	0.49
Comm. About Medicines					1	0.34	0.31	0.36	0.49	0.43
Cleanliness of Hospital Environment						1	0.30	0.18	0.43	0.38
Quietness of Hospital Environment							1	0.14	0.36	0.31
Discharge Information								1	0.29	0.27
Overall Hospital Rating									1	0.75
Recommend the Hospital										1

*Patient-level Pearson correlations of rescaled linear means of HCAHPS measures, for patients discharged between July 2008 and June 2009 (2.4 million completed surveys).

Note: All correlations are significant at $p<0.001$.

Source: HCAHPS Online Website at http://www.hcahpsonline.org/SummaryAnalyses.aspx#correlations

PERFORMANCE AND BASELINE PERIODS

HANYS believes that all VBP measures must have useable, CMS-reported data for a full 12-month baseline and a full 12-month performance period. A complete 12 months of data are necessary to avoid issues with seasonality and bias inherent in small numbers.

HANYS recognizes that, due to program notification timeframes mandated by ACA, CMS is unable to use two 12-month periods of reported data for the first year VBP program (FFY 2013). HANYS supports the proposed use of nine-month baseline and performance periods for the first year only. In subsequent years, however, **HANYS strongly recommends that the VBP performance and baseline periods each comprise of at least 12 months of data.**

HANYS also recommends and requests that CMS post the nine-month baseline and, eventually, performance period scores on Hospital Compare so that providers and provider groups independently can verify the calculations of performance standards and scores.

MINIMUM REQUIREMENTS AND EXCLUSIONS

Under ACA, Critical Access Hospitals (CAHs) and small hospitals with insufficient numbers of measures or cases are to be excluded from the hospital VBP program. CMS is proposing to define a small hospital as any hospital that does not have useable data for at least four of the 17 proposed processes of care measures, or has fewer than 100 responses for the HCAHPS survey.

For the process of care measures, CMS proposes that any measure with fewer than ten reported cases is not useable and should be excluded from a hospital's VBP process domain score calculation. In contrast, on its Hospital Compare Web site CMS states that case counts of less than 25 yield results that are not statistically significant.

HANYS urges CMS to set consistent standards for statistical significance and we recommend that CMS use a count of 25 as the minimum standard for determining the sufficient number of cases for inclusion under VBP.

CMS proposes that hospitals with insufficient data for a measure in the baseline period, but useable data for the performance period, would be included, but would score achievement points only and no improvement points. This puts small hospitals and new hospitals at a disadvantage because they are not able to receive the higher of improvement or achievement points.

HANYS recommends hospitals with measures lacking useable data in the baseline period have those measures be excluded from the VBP program for that fiscal year.

PERFORMANCE STANDARDS FOR ACHIEVEMENT

Under the proposed program, hospitals can earn points for the achievement of high quality standards. CMS proposes to establish, using data from the baseline period, an achievement threshold for each process measure at the national median score and an achievement benchmark at the average score for the nation's top 10% of performers.

MAIN HEADQUARTERS: One Empire Drive / Rensselaer, New York 12144 / (518) 431-7600 / fax (518) 431-7915 / www.hanys.org
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This proposed methodology would yield thresholds and benchmarks that are extremely high and within only a few points of each other for many of the proposed process measures. This "compression" between the benchmarks and thresholds effectively prohibits hospitals from scoring along a full ten-point achievement range.

According to our analysis, 14 of the 17 proposed performance standards would prohibit hospitals from scoring along the full ten-point achievement range.

For the Acute Myocardial Infarction (AMI)-2, the threshold would be 98% and benchmark would be 100%. As a result, the range of possible achievement scores would also be severely attenuated: a score of 100% would result in ten points; 99% would result in five points; 98% would result in one point; and all other scores would receive zero achievement points. This effectively obviates the concept of an achievement range.

HANYS urges CMS to modify its proposal to allow hospitals to score achievement points along the full ten-point achievement range established in the proposed rule. HANYS recommends that CMS adopt a minimum achievement range of ten points. This could be accomplished by setting the threshold to be the lower of the median score value or the benchmark score minus ten points.

SELECTION OF MEASURES

HANYS is pleased that the ACA requires the VBP program be built upon the existing set of measures used in the pay-for-reporting, hospital inpatient quality reporting (IQR) program. We also appreciate that the proposed process measures for FFY 2013 are measures that have been approved by the public-private consensus-based entities—the Hospital Quality Alliance (HQA) and National Quality Forum (NQF). In the future, it is critical that CMS continue to include only measures that have been rigorously evaluated, are based on the most current evidence-based science, and have been approved by HQA and NQF.

NQF and HQA approve a broad spectrum of measures intended to be used for a variety of purposes; not all measures approved by these entities may be appropriate for inclusion in the VBP program. Criteria for evaluating which measures have the greatest likelihood of improving health outcomes have been identified by The Joint Commission and could serve as the basis for further refinement.

HANYS recommends that CMS carefully scrutinize all future measures against pre-established, agreed-upon criteria to determine if a measure is simultaneously relevant to VBP and has at its core the ability to improve health outcomes for patients.[6]

In the proposed rule, CMS sets forth the principles that should guide design of the VBP policy. The principles include: *To the extent possible and recognizing differences in payment system maturity and statutory authorities, measures should be aligned across Medicare's and Medicaid's public reporting and payment systems.* This is in complete alignment with HANYS' recommendations for the design of the VBP. Current and future measures should align with other measures being reported at the federal level.

There has been a proliferation of quality measure reporting requirements for health care organizations over the last decade. Health care organizations are required to report to numerous federal and state databases and reporting systems, many with different interfaces, reporting rules, and deadlines. In some cases, providers are required to report similar measures to different entities, but the measures have variations in their definitions and specifications. These inconsistent approaches to reporting result in duplication and waste, undermine efforts to enhance quality improvement, and confuse stakeholders and the public.

HANYS recommends that any and all future measures incorporated in the VBP program be aligned and do not overlap with other measures currently being reported. Measures must also be approved by HQA and NQF and have been shown to improve health outcomes for patients.

PROPOSED MEASURES FOR SUBSEQUENT YEARS

Mortality Measures

CMS proposes to add mortality measures under a new outcomes domain in FFY 2014. This domain is proposed to include the publicly reported risk-adjusted, all-cause 30-day mortality rates for patients hospitalized with a principle diagnosis of heart attack, heart failure, or pneumonia.

HANYS has strong concerns regarding inclusion of the mortality measures, in their current form. We disagree with the definition and specifications for the measures and recommend that additional exclusions be incorporated to accurately reflect the intent of the measure and the

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[6] Chassin, M.R., Loeb, J.M., Schmaltz, S.P., & Wachter, R.M. (2010). Accountability Measures-Using Measurement to Promote Quality Improvement. *N Engl J Med.* 363(7), 683-688.

clinical conditions that are within a provider's control. Additionally, there is little variation in the data, making it difficult to distinguish between hospitals' performance. Currently, the mortality measures exclude only those patients who were enrolled in a Medicare Hospice program any time during the 12 months prior to the index admission. We believe the method is significantly flawed because it includes patients who arrive at a hospital, are diagnosed with a terminal illness, and are discharged to hospice or placed on palliative care. Without these exclusions, providers may be unfairly penalized for mortalities that are a consequence of the natural course of a patient's illness and therefore outside of the provider's control. These patients can be identified in the administrative data set and issued to CMS.

HANYS urges CMS to exclude patients on hospice or palliative care from the mortality measure sets. Following the redesign of the mortality measures, the revised measures should be posted for one year on the Hospital Compare Web site. CMS should then consider whether there is a meaningful methodology for including them in VBP that will accurately distinguish between hospitals' performance.

Healthcare-Acquired Conditions (HACs)
CMS proposes to include eight Medicare HAC rates in the VBP program in FFY 2014. Currently, hospitals are subject to a HAC payment policy that does not reimburse hospitals for the higher costs associated with treating HACs. Beginning in FFY 2015, ACA mandates another HAC payment program, in addition to the current program, that imposes a 1.0% payment penalty on hospitals with the highest HAC rates.

The ACA recognizes that hospitals should not be penalized multiple times for the same performance. Readmissions measures are expressly excluded from the VBP program because another readmission payment policy was established under the ACA. The same consideration should be given to HAC measures. Therefore, **HANYS strongly opposes inclusion of the HAC measures in the VBP program.**

Agency for Healthcare Research and Quality (AHRQ) Measures
CMS proposes to add nine AHRQ measures to the outcomes domain in FFY 2014. HANYS has several concerns with the inclusion of the AHRQ measures in the VBP program. Some of the AHRQ composite measures proposed to be included in the VBP program are comprised of some measures that are not NQF endorsed. HANYS strongly recommends that all measures included in the VBP program must be endorsed by NQF.

Further, the AHRQ measures have not been sufficiently analyzed and validated across all states, regions, and various types of hospitals and they lack the sensitivity and specificity required for

use in the VBP program. The AHRQ measures are derived from administrative claims data, which do not capture the same specificity as measures derived from clinical chart abstraction. Some of the AHRQ measures have a high false positive rate, meaning that they indicated potential problems, but further investigation showed the care was fine and the indicator was inaccurate.

The AHRQ has been working to amend some of the measure specifications to address these concerns. However, before the AHRQ measures are included in the VBP program, additional field testing and re-specification is needed.

In addition, some measures are duplicative of other measures currently being reported under the Hospital IQR program. HANYS is concerned about the overlap and lack of consistency between the AHRQ measures and similar measures currently being reported by hospitals and used for other pay-for-performance policies. For example, the AHRQ "Complications/patient safety for selected indicators" composite measure includes decubitus ulcer. The current Medicare HAC payment policy and the HAC payment policy established by the ACA for FFY 2015 also include stage III and IV decubitus ulcers. Including decubitus ulcers in the VBP program under the AHRQ composite measure may cause hospitals to be penalized multiple times for the same performance.

If CMS incorporates the nurse-sensitive measure set into VBP, there will be a third unique approach for defining and reporting HAC information. The variation and multiple policies will impose additional reporting burdens on hospitals and result in reporting inconsistent rates to the public.

Before the AHRQ measures are included in the VBP program, HANYS recommends that the measures be approved by the NQF, undergo additional field testing and re-specification, and be aligned and consistent with other measures currently being reported.

EFFICIENCY MEASURES

Beginning no earlier than FFY 2014, the ACA requires that a number of efficiency measures be included in the VBP program. The measures must include Medicare spending per beneficiary; and be adjusted for age, race, sex, severity of illness, and other factors deemed necessary by the

Secretary. In the proposed rule, CMS requests recommendations on how such an adjustment should be calculated.

There are no generally accepted, validated measures of hospital efficiency and much work must be done before accurate and equitable efficiency measures can be incorporated into payments.

The HHS Secretary has commissioned an Institute of Medicine (IOM) study to examine geographic variation in service use and spending. The Secretary directed IOM to consider in its study the extent to which geographic variation can be attributed to differences in:

- **input prices**—the costs associated with buying all of the goods and services needed to care for patients;
- **practice patterns/utilization**—variations in the delivery of care;
- **patient access to health services**—not every community has the luxury of a strong health care delivery system;
- **socio-economic factors**—income levels, race, education, and cultural variations result in differences in patient needs and treatment patterns;
- **health care outcomes**;
- **market factors and regulatory issues**—the cost of medical malpractice insurance, for example; and
- **provider organizational models**—variation in care delivery systems from one community to the next.

HANYS is urging IOM to consider other important variables including patient health status and Medicare payment policies like Indirect Medical Education and Disproportionate Share Hospital adjustments directed to hospitals that perform the special mission of training physicians and caring for a high proportion of uninsured, underinsured, low-income, and Medicaid patients.

HANYS recommends that CMS avoid duplication of effort and wait for IOM to release its findings before beginning work on efficiency measures for use in the VBP program.

SUB-REGULATORY PROCESS

CMS proposes to implement a sub-regulatory process for adding and retiring measures to/from the VBP program. CMS proposed a similar sub-regulatory process for the Hospital IQR program

in 2008; however, after receiving strong objections from various stakeholders, CMS did not implement its proposal.

HANYS strongly believes that the provider community must have adequate, routine input regarding the addition or elimination of measures for the VBP program—in short, there should be a defined process. Careful consideration and implementation of measures will support VBP program stability.

HANYS strongly opposes a sub-regulatory process and recommends that any program changes be made through the traditional rule-making process that seeks public comment on a regular basis. HANYS also recommends that CMS synchronize its notification for the Hospital IQR program with the VBP program in one rule-making cycle. To maintain stability in the VBP program, CMS should limit the number of measures/domains that can be added or deleted each year.

APPEALS PROCESS

The ACA requires the Secretary to establish a process whereby a hospital can appeal the calculation of its VBP performance assessment. CMS did not include an appeals process in this proposed rule. Without an established appeals process, there are likely to be indirect consequences that could have a substantial and devastating impact on hospitals' scoring and payment. CMS encountered this issue during the development of the pay-for-reporting program where an inconsequential typing error (e.g., mistyped birth date) affected a hospital's scoring and payment. Without a well considered, rational appeals process for addressing these types of situations, providers are left without recourse for addressing legitimate injustices.

HANYS urges CMS to develop a clear, streamlined, and fair appeals process that provides a mechanism for addressing significant provider concerns. That process should be outlined in the VBP final rule.

NOTIFICATION PROCESS

The ACA requires hospitals to be informed of the payment adjustments to their base operating Diagnosis Related Group payment amount, no later than 60 days before the fiscal year involved. However, due to timing of the performance period (July 1, 2011-March 30, 2012) and the actual

federal fiscal year start date (October 1, 2012), CMS states that it will not have sufficient time to calculate final total performance scores or final VBP incentive payments 60 days before the start of FFY 2013.

CMS proposes to inform hospitals through their QualityNet accounts, 60 days prior to October 1, 2012, of their estimated VBP incentive payment—based on the most recently available data. CMS will then notify each hospital on November 1, 2012 of their exact VBP incentive payment adjustment. The value-based adjustment would be incorporated into the claims processing system in January 2013 and would allow the VBP incentive payment adjustments to be applied to the FFY 2013 discharges, including those that occurred beginning October 1, 2012.

HANYS would prefer that CMS notify hospitals of their actual/final VBP scores and payment percentages prior to the start of the fiscal year and avoid reprocessing claims altogether. Requiring hospitals to re-bill for each claim between October and December will cause an unnecessary burden on hospitals. If CMS is unable to modify its proposed notification timeframes, HANYS asks CMS to clarify that it will automatically reprocess all claims submitted prior to January 1.

QUALITY IMPROVEMENT ORGANIZATION (QIO) QUALITY DATA ACCESS

HANYS echoes the comments of the American Hospital Association regarding CMS access to QIO quality data. 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. HANYS is extremely concerned that the changes CMS proposes to make with regard to access to QIO information will strip away many of the confidentiality safeguards and will be in conflict with Congress' original intent for putting the confidentiality provisions in place.

Section 1160 of the Social Security Act protects the confidentiality of QIO information, requiring this information to be held in confidence by the QIO and making 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 which is exactly the effect intended by the law and implementing regulations. 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, 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, as a result, 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 voluntary QIO activities.

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 have the unintended consequence of discouraging hospital participation.

HANYS strongly urges CMS not to make the proposed changes to the QIO regulations. We urge CMS not to allow the disclosure of QIO information to researchers.

HANYS appreciates the opportunity to comment on the proposed design for the Hospital VBP program. We look forward to continuing to engage in a constructive dialogue on this issue.

Please contact Kathleen Ciccone, Executive Director, HANYS Quality Institute, at (518) 431-7756 or at kciccone@hanys.org; or Stephen Harwell, Vice President, Economics, Finance, and Information, at (518) 431-7777 or at sharwell@hanys.org with any questions or comments.

Sincerely,

Daniel Sisto
President

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