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

Ref: CMS–3239–P: Medicare Program; Hospital Inpatient Value-Based Purchasing Program

Dear Dr. Berwick:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned Proposed Rule. NAPH represents more than 140 metropolitan area safety net hospitals and health systems that all share the common mission of providing high quality health care to all patients regardless of ability to pay. NAPH members predominantly serve the uninsured and patients covered by public programs. In fact, NAPH members represent only 2 percent of acute care hospitals nationally, yet provide 20 percent of all hospital compensated care. Over the years, many NAPH members have had to figure out the most efficient way to provide care to vulnerable patients with complex medical needs. A key step in achieving this goal is a commitment to providing high quality care. Toward that end, NAPH members have undertaken efforts to improve physician alignment and to engage the hospital leadership—almost 90 percent of NAPH members share quality performance data with their physicians and 80 percent engage their boards of directors in quality improvement activities. Through these efforts, NAPH members have been able to effectively improve the health of the most vulnerable patients in their communities. Now more than ever, at a time when NAPH members are caring for more needy individuals and facing the possibility of significant cuts due to budget crises at the state and federal levels, value-based purchasing (VBP) incentive payments are critical to support the investments NAPH members have already made and are continuing to make in quality.

NAPH believes that the VBP Proposed Rule is an excellent first step toward improving quality and patient safety and thanks CMS for issuing a thoughtful, comprehensive rule to implement the VBP program mandated by the Affordable Care Act (ACA). We recognize the importance of getting the measures and incentives right so that real improvements of care can be

identified and rewarded; and poorer performances can be identified so that resources, which are often scarce, can be targeted to areas that will have the greatest impact on patients. Toward that end, NAPH looks forward to partnering with CMS to accomplish this goal—NAPH's new Transformation Center is the ideal incubator for testing and developing strategies to improve performance on quality measures and disseminating these, along with existing strategies identified by CMS and the Agency for Healthcare Research and Quality, to hospitals that care for the most vulnerable patients, including those dually eligible for Medicaid and Medicare.

NAPH highlights the following aspects of the Proposed Rule as areas where the measurement of quality and the methodology for determining incentives can be better aligned so that the VBP program can achieve the goal of raising the overall quality of care in the current health care system.

1. Weighting of Quality Measures

For fiscal year (FY) 2013, CMS has proposed to assign a weight of 70 percent to clinical process of care measures and a weight of 30 percent to measures captured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. **NAPH recommends that CMS adopt a weight for HCAHPS measures no higher than 15 percent in the final rule.** While we recognize that the HCAHPS survey is an important tool to capture data on the patient's experience of care, an indicator of patient and family engagement and a key aspect of quality, there are critical weaknesses in the HCAHPS survey that need to be researched and improved before the survey is used to dictate a substantial portion of hospitals' VBP incentive payments—almost one third in the Proposed Rule.

In particular, as the National Quality Forum has recognized, research is needed to assess whether the HCAHPS survey adequately captures hospitals' cultural competence and the patient care experiences of patients who speak languages other than English or Spanish.[1] One recent study concluded that the HCAHPS survey lacks measures of cultural competence, and therefore fails to capture key aspects of health care quality that are important to racial and ethnic minority groups.[2] This flaw in the HCAHPS survey unfairly disadvantages hospitals that treat a higher proportion of minority and non-English primary language patients—e.g., the majority of discharges at NAPH member health systems are for patients who are members of racial and ethnic minorities. NAPH members see the value and benefit of providing culturally competent care and urges CMS to structure the VBP program to encourage improvements in cultural competency and reductions in health care disparities. If the HCAHPS survey, as it is currently structured, is assigned too high a weight, NAPH is concerned that the VBP program will not serve this important goal.

NAPH also is concerned that the risk-adjustment methodology currently used for the HCAHPS survey does not adequately adjust for biases related to the use of emergency care and other specialized services that require patients to transfer to safety net providers outside their communities. Many NAPH members provide burn, trauma, neonatal, and other specialized

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[1] NATIONAL QUALITY FORUM, STANDARDIZING A MEASURE OF PATIENT PERSPECTIVES OF HOSPITAL CARE (2005).
[2] A. Bagchi, R. Ursin, & A. Leonard, *Assessing Cultural Perspectives on Healthcare Quality*, J. IMMIGRANT & MINORITY HEALTH (Oct. 14, 2010).

services that are otherwise unavailable in their communities and, as a result, see a disproportionate share of patients who are transferred to NAPH hospitals and who may be unfamiliar with the hospital and the community. Patients who receive emergency care or experience traumatic events that require hospital transfers have been found to rate their overall hospital experience lower than patients receiving scheduled care in their own community.[3] Although the current HCAHPS survey does adjust somewhat for emergency treatment, we fear that CMS does not adequately account for hospitals with high volumes of patients seeking emergency care and transfer patients, leaving safety net hospitals at an unfair disadvantage.

NAPH agrees with other hospital organizations, including the American Hospital Association (AHA) and the Association of American Medical Colleges, that other factors—e.g., length of stay, patient severity of illness, and teaching status—may result in systematic bias in the HCAHPS survey methodology. NAPH directs CMS to the comment letters of these organizations for a more detailed discussion.

2. HCAHPS Scoring Methodology

CMS proposes that 20 percent of a hospital's total HCAHPS performance score be based on a consistency score, which measures whether a hospital meets or exceeds the achievement threshold for each of the eight HCAHPS dimensions. As a result, 20 percent of a hospital's HCAHPS performance score would be based solely on achievement and would be unaffected by improvement. Thus, under the Proposed Rule, hospitals would not have the same opportunity to earn incentive payments based on improvement as they do for the clinical process of care measures..

NAPH recommends that CMS award points based on consistency in achievement *or improvement* across HCAHPS dimensions. The calculation of a consistency score based only on achievement, and not improvement, is inconsistent with Congress's statutory mandate to determine a hospital's total performance score "using the higher of its achievement or improvement score for each measure." Moreover, a consistency score based only on achievement establishes a minimum performance score, contrary to Congress's mandate to the Secretary "not [to] set a minimum performance standard in determining the performance score for any hospital." Even CMS referred to an achievement-based consistency score as a "minimum performance score" in its 2007 Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program. Expanding the consistency score to capture improvement across all HCAHPS dimensions would bring the consistency score into compliance with the mandates of the ACA and would reward hospitals equally for achievement and improvement.

3. Risk Adjustment

We applaud CMS for recognizing in the Proposed Rule that measures included in the VBP program should be risk-adjusted. We encourage CMS to be transparent in the risk-adjustment methodologies that it ultimately adopts. In addition, we recommend that CMS consider for

[3] *See, e.g.*, PRESS GANEY, 2010 HOSPITAL PULSE REPORT: PATIENT PERSPECTIVES ON AMERICAN HEALTH CARE 7 (2010).

inclusion in risk-adjustment methodologies both demographic and socioeconomic factors, including age, sex, race, ethnicity, language, income, education, health literacy, insurance status (including measures of underinsurance), disease and functional status (including comorbidities), post-discharge care support structure (including abode), and access to primary care. Appropriate risk-adjustment is critical to ensuring that quality measures represent real improvements in care, rather than penalizing hospitals for patient mix, insurance status, hospital size, geography, and other factors unrelated to quality and beyond the control of providers.

Given the importance of risk-adjustment, we strongly encourage CMS to develop and validate risk-adjustment methodologies before adding new measures to the VBP program. In particular, we do not believe hospital-acquired conditions (HACs), mortality measures, and AHRQ patient safety and quality indicators currently have adequate risk-adjustment methodologies. We concur with the AHA that these measures are not yet ready for inclusion in the VBP program and refer CMS to their comment letter for additional detail.

4. Addition of HAC Measures in FY 2014

For FY 2014, CMS proposes to add to the VBP program measures of hospital-acquired conditions (HACs). **Because HACs are subject to penalties under a separate and distinct section of the ACA, we oppose their inclusion in the VBP program.** Pursuant to section 3008 of the ACA, beginning in FY 2015, hospitals in the top quartile of national, risk-adjusted HAC rates in a year will receive only 99 percent of their otherwise applicable Medicare payments the next year. As with readmissions measures, there should be only one set of rules and payment penalties associated with HACs.

5. Total Hospital Performance Score

CMS has proposed to translate each hospital's total performance score into an incentive payment amount using a linear exchange function. **We encourage CMS to instead adopt a cube root exchange function, at least during the initial years of the VBP program.** We believe that as Medicare payments shift away from fee-for-service and toward pay-for-performance, it is important to establish a baseline level of quality at all hospitals and to encourage hospitals at all levels of performance to invest in quality improvement. Once the quality of all hospitals has been raised to a baseline threshold, shifting to a linear exchange function that rewards all hospitals equally—i.e., the same marginal incentive for higher or lower performing hospitals—for quality achievement and improvement may be appropriate.

CMS also proposes to exclude from the VBP program seven "topped out" measures for which hospital performance was statistically indistinguishable at the 75th and 90th percentiles and for which the hospitals' scores were tightly clustered around the average score. For the reasons that CMS laid out, NAPH agrees with CMS that these measures should be excluded. Along the same reasoning, NAPH urges CMS to reconsider three additional measures—AMI-2: Aspirin at Discharge, HF-2: Evaluation of LVS function, and SCIP-INF-2: Surgical Patients Given the Right Kind of Antibiotics. For these three measures, the difference between the national median and the national benchmark is only one or two percentage points; however, the corresponding difference in the VBP score, as it is proposed in the rule, can be nine points. In other words, a

hospital with performance at the national threshold will earn a VBP score of one for that measure and a hospital at the national benchmark will earn a VBP score of ten. Not only is it difficult to measure discernable changes in improvement, hospitals also will have to redirect resources from other quality improvement projects to try to move their performance on a particular measure from near perfect to 100 percent. Moreover, establishing thresholds at or near 100 percent may in fact result in care that is clinically inappropriate, as hospitals seek to achieve 100 percent performance for clinical process measures that do not and cannot account for each patient's unique circumstances. For example, it may be impossible for a hospital treating a patient with traumatic injuries to more than one system to satisfy the SCIP antibiotic criteria because different antibiotics are required for the different injuries. Hospitals should not be penalized under the VBP program where quality measures are not aligned with clinically appropriate care. To address these concerns, **NAPH concurs with the AHA's proposal to change the methodology for calculating achievement thresholds and benchmarks and urges CMS to adopt the AHA's proposal in the final rule.**

6. Subregulatory Process

CMS proposes a subregulatory process for the addition of new measures to the VBP program. **We strongly encourage CMS to instead use notice and comment rulemaking to adopt new measures.** For the VBP program to serve its purpose of improving quality of care, hospitals need sufficient time to collect and analyze data and adopt quality improvement strategies before quality measures impact payment. CMS suggested in the Proposed Rule that the adoption of a subregulatory process is justified by the need to urgently adopt new measures to address patient safety risks. However, many of the quality measures currently reported under the Inpatient Quality Reporting (IQR) program from which the VBP program measures are and will be drawn (for example, HCAHPS measures), relate to efficiency, patient-centeredness, and other aspects of quality not directly related to patient safety. We believe notice and comment rulemaking will allow for thoughtful dialogue on the usefulness and appropriateness of including quality measures in the VBP program without causing undue delay.

In addition, notice and comment rulemaking will allow CMS to assess the most efficient way to achieve the VBP program's goals, without leaving any hospitals behind. For example, CMS proposes to include the Nursing Sensitive Care measures in the VBP program for FY 2014 and beyond. In order for a hospital to perform well on these measures, it would need to participate in a fee-based database registry. During a notice and comment period, CMS can solicit feedback on the best way to make sure that all hospitals are on equal footing with respect to their ability to perform on these measures.

7. Applicability of VBP Program to Hospitals

For hospitals that have data for the performance period, but not for the baseline period, CMS proposes to include them in the VBP program, but only evaluate them on achievement—not on improvement. **NAPH urges CMS to consider excluding hospitals without baseline data from the VBP program.** As noted earlier, NAPH believes that it is important to establish a baseline level of quality at all hospitals and to encourage hospitals at all levels of performance to invest in quality improvement. For that to happen, all hospitals should be given the same

opportunity to earn incentive payments. Hospitals without baseline data will not have the chance to earn points based on improvement, which puts them at a disadvantage. This is inconsistent with the statutory mandate to determine a hospital's total performance score "using the higher of its achievement or improvement score for each measure." Hospitals without baseline data would have 1 percent of their base operating DRG payments withheld—like all other hospitals in the VBP program—however, their ability to recover a portion or all of the payments withheld will be based only on their ability to reach the achievement threshold, and not on improvement. NAPH believes that it is more appropriate to include these hospitals in the VBP program during the following fiscal year when CMS has both baseline and performance period data.

8. Interaction of VBP and IQR Programs

The Proposed Rule indicates that hospitals who fail to report quality data under the IQR program will be excluded from the VBP program, and therefore will not be subject to double penalties. NAPH supports this policy. However, we believe there still is widespread confusion about the interaction between the IQR and VBP program over the long-term. **We encourage CMS to address in the final rule whether the IQR and VBP programs will remain separate or will be consolidated over time.**

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NAPH appreciates the opportunity to submit these comments. If you have any questions about these comments, please contact Xiaoyi Huang at (202) 585-0100.

Sincerely,

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Chief Executive Officer