



March 4, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3239-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Comments on the Proposed Rule for the Medicare Program; Hospital Inpatient Value-Based Purchasing Program; 42 CFR Parts 422 and 480; CMS-3239-P; RIN 0938-AQ55

Dear Dr. Berwick:

The Rural Policy Research Institute (RUPRI) Health Panel appreciates the opportunity to comment on the proposed rule for Medicare's inpatient hospital value-based purchasing (VBP) program. RUPRI supports high-quality, accessible, and efficient health care for rural people and places and is pleased to comment on this important Medicare program.

Appropriate Measures

The proposed VBP rule is precedent-setting and will impact many rural hospitals. Since rural hospitals may provide a different mix of services than large urban hospitals, it is critical that the Centers for Medicare and Medicaid Services (CMS) develop VBP performance measures "appropriate to the specific provider category that reflects the level of care and the most important areas of service and measures for that provider." Thus, measures should assess services regularly provided in rural hospitals.

Achievement and Improvement

We are very pleased to see that CMS will be using both achievement and improvement scoring methodologies. Many rural hospitals are justifiably proud of their quality improvement efforts and results, and should not be penalized for historic good performance. By rewarding both achievement and improvement, all hospitals (including rural and low volume facilities) should be incentivized to take action, either maintaining excellence or improving suboptimal performance. We are also pleased that measure reliability (repeatability) will be assessed. Statistical reliability is a critical issue for rural hospitals with low volumes. We will further consider the issue of reliability below.



Data Presentation

The proposed rule does not make clear which data will be posted on Hospital Compare versus other CMS websites. The presentation of performance data is challenging – data presentation should lead to informed beneficiary decisions that are not influenced by statistical errors caused by low volumes or misinterpreted information caused by poor web page design. We suggest that CMS work diligently to ensure that the decision to not display data about a particular hospital or hospital group does not lead to erroneous public interpretations of poor performance in that hospital or hospital group.

Comment Periods

We agree that rapid implementation of additional measures may be important to patient safety. However, avoiding unintended consequences of the VBP program is also critical. If a measure is to be added to the VBP program without the necessity of comment and rule-making, there should be increased opportunity for stakeholder input during selection and development of measures that later may be used in Hospital Compare and the VBP program.

Data Baseline

CMS proposes to use a 3-quarter data baseline. Evidently, statistical modeling does not suggest a significant difference between the 3-quarter time period versus a year or longer. However, low-volume statistical issues may be compounded by short time periods. Statistical analysis of national data may not capture this dilemma. CMS and its contractors should consider assessing 3-quarter data reliability specifically in low-volume hospitals.

Eligible Measures

CMS requests comment regarding the “Initial Eligible Measures.” In general, the non-SCIP measures will be applicable for most, but not all, rural acute care hospitals. CMS should review AMI-7a and AMI-8a to ensure that intervention timing is based on the time the ST-elevation heart attack is diagnosed (by electrocardiogram). Thus, time from hospital arrival to electrocardiogram may still be important, yet it is not included in CMS’ initial set of eligible measures. CMS weights surgical care highly by including several SCIP measures. As the VBP program expands, CMS should recall that not all acute care hospitals provide surgical services. Therefore, alternative measures may be needed that “reflect the level of care and the most important areas of service and measures for that provider.”

Topped-out Measures

We understand the desire to delete “topped-out” measures. Although the coefficient of variation suggests tight clustering of topped-out measure performance, we wonder about the lost opportunity to demonstrate improvement in these scores. Thus, we recommend that CMS evaluate whether deleting “topped-out” measures might disadvantage hospitals with significantly improving performance over time.



Outcome Measures

Although we philosophically support the use of outcome measures (as opposed to process measures) to assess hospital performance, the volumes necessary to achieve statistical reliability in outcome measure use is significant. This issue is obviously most problematic in low-volume hospitals. For these reasons, we applaud the mortality measure change from a one-year reporting period to the use of a three-year rolling average. CMS acknowledges that reliability concerns were the impetus for this change. Therefore, if CMS extended the reporting period to include more volume and consequently improve outcome measure statistical reliability, CMS substantiates our concern about outcome (especially mortality) measures in low-volume hospitals. We urge CMS to implement outcome measures (e.g., mortality and AHRQ PSI/IQI measures) very cautiously, using robust statistical analysis to demonstrate measure reliability before implementation, especially in low-volume situations. Mortality measures especially deserve careful consideration for unintended consequences. For example, in some communities patients come to the hospital to die, especially if home health or hospice services are underdeveloped or unavailable. Thus, hospitals that previously eased the transition to death with care and compassion may now discourage admissions in which the patient is likely to die.

Transfer of Care

It appears that the proposed regulations do not consider performance measurement for patients transferred between hospitals. Ideally, performance should be attributable to the hospital where the service was (or should have been) provided. However, when a patient is transferred from one hospital to another, attributing a summation of performance measures to a single hospital will be problematic. This is an important issue for rural hospitals in which patient transfers may be more likely to occur. Attributing performance to the hospital at which the patient was discharged seems most appropriate, but we would like to explore alternatives proposed by CMS.

Proposed Measures

We note that the proposed measures include SCIP measures under the healthcare-associated infections domain. CMS should be aware that a hospital not providing surgical services would not have an opportunity to demonstrate healthcare associated infection reductions in non-surgical areas. Similarly, a hospital with exceptional healthcare-associated infection reduction policies (e.g., urinary catheter policies), but less developed SCIP policies, will also not have the opportunity to demonstrate good performance. Therefore, we suggest reconsideration of non-SCIP healthcare-associated infection measures.

Efficiency Measures

In the high fixed-cost environment of the hospital, increasing volume decreases unit cost and may increase measurable efficiency (depending on the efficiency assessment methodology). Low-volume rural hospitals may be inappropriately disadvantaged if the efficiency metric is based on service volumes. Several approaches may ameliorate this concern. Hospitals with similar volumes should be compared to one another. Part A and Part B costs, plus non-operational Medicare program costs, should be considered in the efficiency calculation. To avoid gaming the efficiency measure, costs for a reasonable period of time before and after the



hospitalization should be included. We believe that academic medical facilities will wish to exclude Medicare payments for training during efficiency calculation. If GME and similar education costs are excluded from efficiency calculations, then costs for training at rural hospitals should be similarly excluded.

Scoring

We support CMS' decision to include both an achievement and an improvement scoring system, using whichever method results in a higher score to represent the hospital's overall performance score. Although the system is somewhat complicated, it appears fair. The three domains are also generally acceptable, but outcome measures and low-volume concern should be carefully addressed. Similarly, the decision to use a linear exchange function to determine value-based incentive payments is the most easily explained and understood of the options considered. Although CMS expresses VBP program implementation urgency, developing a "shadow" accounting process for one year prior to program implementation, to show each hospital how it would fare financially under the program, would be helpful for hospital strategic planning and would have likely resulted in positive behavior change without financial risk.

2014 Measures

As new measures are added, CMS should note that many hospitals will not provide these services or experience these conditions. Thus, we will reiterate CMS' original VBP program intent that the measures should be "appropriate to the specific provider category that reflects the level of care and the most important areas of service and measures for that provider."

70/30

CMS proposes to weight clinical process of care measures as 70% of the total performance score and patient experience measures as 30% of the total performance score. We wonder how this proportion was determined. Statistical reliability will be less of a concern in the patient experience measures (100 cases minimum). Thus, we suggest that the patient experience measures be weighted equally with the clinical process of care measures (50/50). This change in performance weighting would also allow new and ongoing hospital performance improvement efforts (e.g., through CMS directly, Center for Medicare and Medicaid Innovation, Quality Improvement Organizations, and other Department of Health and Human Services programs) to produce results. As quality improvement, measurement, and reporting becomes more sophisticated, and the public becomes more cognizant of quality scoring and its implications, performance weighting might then move gradually back to the 70/30 proportion originally proposed.

HCAHPS

We are pleased to see that the HCAHPS measure, "Would you recommend this hospital?" will not be considered in the scoring. We have found that patients may have an exceptionally good experience at a hospital with limited services, but would not recommend that hospital because tertiary services (for example) were not available locally.



Minimums

We understand the tension between minimum volumes necessary for statistical reliability and the intent to include as many hospitals as possible in the VBP program. Brandeis researchers suggest that a minimum of 4 measures and a minimum of 10 cases for each measure provide adequate reliability to determine performance. We recommend that CMS regularly reassess statistical reliability of its 4/10 minimum decision to ensure that low-volume hospitals are not penalized for normal variation.

Hospital Comparisons

We wish to highlight and applaud CMS' comment that the "VBP program should make fair comparisons between hospitals based on total performance scores that are affected predominantly or exclusively by the hospital's performance on the individual measures." CMS continues to note that "differences in the TPS between hospitals may also be affected by differences in the scope of services offered, which would determine the mix of measures that comprise the TPS for each hospital. Thus, a critical aspect of developing and implementing the TPS is facilitating equivalent and accurate comparisons between hospitals." Service mix differs between hospitals. The VBP program should measure those services regularly provided at a particular hospital and compare performance of like hospitals.

Monitoring and Evaluation

VBP program monitoring for expected improvements and unintended consequences secondary to the program is critical. Therefore, we are pleased that the program will be evaluated for its impact on 1) access to care, 2) practice changes, 3) patterns of care, and 4) diffusion of best practices. Access to care assessment can be difficult. We suggest that overall service utilization is not a good proxy for access and that important regional/local differences may not be adequately assessed in national surveys. Creative access-to-care assessments, such as discretionary service (e.g., prevention services) utilization or beneficiary burden of access metrics, are needed.

Small Rural Hospital Impact

We disagree with CMS that the proposed rules will not have an impact on a "substantial number of small rural hospitals." There are 716 acute care, prospective payment system (PPS) hospitals of less than 100 beds located in non-metropolitan areas (American Hospital Association data). The VBP program will likely have a greater impact on these small rural hospitals than on large urban hospitals. Care process improvement, data measurement, and performance reporting investments (while necessary) are relatively much more costly for low-volume hospitals because these costs cannot be spread over a large number of patient encounters. We are also concerned about performance measure statistical reliability in low-volume situations, such as in small rural hospitals. Thus, we believe that section 1102(b) of the Patient Protection and Affordable Care Act does demand an analysis of the impact on the operations of small rural hospitals (defined as less than 100 beds and located in non-metropolitan areas).

Thank you for this opportunity to comment. We believe that CMS' VBP program will be precedent-setting, with impacts likely to extend well beyond the current scope of proposed



regulations. Importantly, and to reiterate, we strongly agree with CMS that the VBP program and its measures should be “appropriate to the specific provider category that reflects the level of care and the most important areas of service and measures for that provider.” Please contact us for additional information or clarification.

Sincerely,

The RUPRI Health Panel

Keith J. Mueller, PhD (Chair and principal author)

A. Clinton MacKinney, MD, MS (principal author)

Jennifer P. Lundblad, PhD, MBA

Andrew F. Coburn, PhD

Timothy D. McBride, PhD

Sidney D. Watson, JD