

March 4, 2011

Donald M. Berwick, M.D.  
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: File code CMS-3239-P**

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled Medicare Program; Hospital Inpatient Value-Based Purchasing Program, published in the *Federal Register*, vol. 76, no. 9, pages 2454 to 2491. We appreciate your staff's ongoing efforts to administer and improve the Medicare payment system for inpatient hospital services, particularly considering the agency's competing demands.

The Commission strongly supports using Medicare payment policy to reward providers for improving the quality and efficiency of care for Medicare beneficiaries. We recommended the adoption of a Medicare inpatient hospital value-based purchasing (VBP) program, which we referred to as pay-for-performance, in our March 2005 report to the Congress. In that report, we laid out the following four design criteria for all Medicare VBP programs:

- **Reward providers based on both improving care and exceeding certain benchmarks.** The goal of a VBP program is to improve care for as many beneficiaries as possible. Thus, it is important to reward both providers who attain certain thresholds of performance and those who improve meaningfully on quality and efficiency measures.
- **Fund VBP bonuses by setting aside a small proportion of provider payments, at least for the initial years of the program.** To ensure minimal disruption for beneficiaries and providers, the Commission recommended that, at least initially, the percentage of dollars should be small (perhaps 1 percent to 2 percent of payments). As the science and administrative feasibility of performance measurement improves, this amount should increase significantly.

- **Distribute all of the funds in the VBP bonus pool to providers that meet the performance criteria.** Although program savings could accrue from providers' improvements in the quality and efficiency of care, the primary goal of the Commission's pay-for-performance recommendations is improved quality of care, not necessarily reduced program spending. Therefore, the Commission recommended that all of the funding withheld to fund the VBP program should be distributed back to providers that meet specified performance measures.
- **Use performance measures that meet certain criteria.** The Commission outlined several criteria that the performance measures used in a Medicare VBP program should meet:
  - Measures should be well-accepted, evidence-based, and familiar to providers.
  - Collecting and analyzing measurement data should not be unduly burdensome for either providers or CMS.
  - The measures used should not discourage providers from treating more complex or higher-risk patients. The use of risk adjustment techniques is particularly critical for outcome measures, such as mortality rates.
  - Most providers should be able to improve performance against the available measures. That is, the aspects of care being measured should be within the control of the provider, there should be room for improvement in the quality measures used, and the measure set should include measures that apply to all patients, such as safe practices and patient perceptions of care.

We note that the Congress incorporated many of these design principles in the Patient Protection and Affordable Care Act of 2010 (PPACA) provision authorizing the inpatient hospital VBP program (section 3001), and they are consistent with the principles that CMS states it applied in developing the proposed rule.

Our specific comments in this letter address the following sections of the proposed rule:

- Performance period (section II.B.)
- Measures, including quality and efficiency measures (section II.C.)
- Methodology for calculating the total performance score (section II.E.)
- Applicability of the VBP program to hospitals, including hospitals with small numbers of cases or small numbers of applicable performance measures (section II.F.)
- The exchange function (section II.G.)

## **Performance period (section II.B.)**

### *Summary of proposed rule*

Section 3001 of the PPACA requires that the inpatient hospital VBP program must begin to affect payments to eligible hospitals in FY 2013. The law also requires that the performance period upon which such payment adjustments are based must begin and end prior to the beginning of such fiscal year. Lastly, CMS also must build into the implementation schedule a sufficient length of time after the end of the performance period for final submission of performance measure data by participating hospitals; post-submission data validation by CMS; CMS calculation of hospitals' preliminary performance scores; CMS notification to hospitals of their preliminary performance score and VBP payment adjustment in the upcoming fiscal year (which the law requires must be done at least 60 days before the start of the upcoming payment year); and time for hospitals to review CMS's performance score calculations and proposed payment adjustments, and to appeal for a reconsideration of the initial calculation if they believe it is warranted.

Given these constraints on the implementation timeline, CMS proposes—for the FY 2013 VBP payment determinations only—to use a three-quarter performance period from July 1, 2011 through March 31, 2012. Hospitals' performance during that period, on the final set of performance measures that will be announced in the hospital VBP final rule, would be compared to the three-quarter baseline period of July 1, 2009 through March 31, 2010. By ending the performance period for FY 2013 on March 31, 2012, CMS would allow 6 months for the post-performance period steps described above.

The agency also states that it anticipates proposing to use a full-year performance period after the initial year of the VBP program (i.e., starting with the FY 2014 VBP payment adjustments). If they continue with the initial proposed policy of ending the performance year 6 months prior to the start of the VBP payment adjustment year, the FY 2014 performance period for the clinical process of care and patient experience (HCAHPS) measures would be the 12-month period of April 1, 2012 through March 31, 2013.

An exception to the general rule of having a 12-month performance period would be the three 30-day mortality measures that CMS proposes to add to the VBP program in FY 2014. For these measures, CMS proposes to use an 18-month performance period. For example, the first performance period for these measures would be July 1, 2011 through December 31, 2012, which would be compared to a baseline period of July 1, 2008 to December 31, 2009. For the other outcome measures that CMS discusses for possible use in the FY 2014 VBP program—eight CMS-designed hospital-acquired condition (HAC) measures, six AHRQ Patient Safety Indicators, and three AHRQ Inpatient Quality Indicators (i.e., in-hospital mortality rates)—CMS does not propose a specific performance period at this time.

### *Comments*

We support the proposal to use a nine-month performance period only for the first year of the VBP program to accommodate the significant constraints on the initial implementation timeline. We also agree with CMS's proposal that, for FY 2014 and subsequent years of the VBP program, the performance period should use a full year of data for the clinical process of care measures and the patient experience (HCAHPS) measures.

For the mortality rate measures, we generally support the proposal to initially use an 18-month performance period, but urge CMS before making a final decision for the FY 2014 VBP program to carefully evaluate the statistical reliability of these measures using the proposed performance period and the 36-month performance period currently used for these measures on the Hospital Compare website. We appreciate the difficult trade-off between a longer period, which will increase the measures' statistical accuracy, and a shorter period that would provide more timely feedback to hospitals on the impact of their care delivery processes on their rates, as well as allow these important outcome measures to be used in the VBP program sooner. Therefore, in the proposed rule for the FY 2014 VBP program, we urge CMS to present a detailed analysis of the effects on statistical reliability and accuracy of using performance periods of various lengths for any proposed mortality rate measures.

### **Measures (section II.C.)**

#### *Summary of proposed rule – Quality measures*

To calculate FY 2013 VBP payment adjustments, CMS proposes to use 18 quality measures that are already in use for the Hospital Inpatient Quality Reporting (IQR) program, categorized into two domains: 17 clinical process of care measures (the "process of care" domain) and one measure from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (the "patient experience of care" domain). CMS notes that there are 45 measures specified under the Hospital IQR program for FY 2011 and describes how that number was narrowed down to the 18 proposed measures:

- *Readmission rate measures* – The three 30-day readmission rate measures currently displayed on Hospital Compare cannot be used in the hospital VBP program because they are specifically excluded by the PPACA provision. A separate payment policy adjustment based on hospitals' readmission rates will go into effect in FY 2013.
- *New measures* – Several potential measures do not meet the statutory requirement that all of the measures used in the VBP program must be displayed on the Hospital Compare website for at least one year prior to the beginning of the applicable performance period for a given VBP payment year. Because CMS proposes to make July 1, 2011 through March 31, 2012 the performance period for the FY 2013 VBP program, only measures that were displayed on Hospital Compare as of July 1, 2010 may be considered for use in

the FY 2013 VBP program. CMS states its intention is to add new measures to the VBP program as soon as they meet this one-year Hospital Compare display requirement.

- *Structural measures* – CMS proposes to exclude three structural measures currently on Hospital Compare that indicate if a hospital participates in a systematic clinical database, such as a registry, for cardiac surgery, stroke care, and nursing sensitive care.
- *“Topped-out” measures* – CMS proposes to exclude seven current process of care measures because they are “topped out,” meaning that all but a few hospitals have achieved a similarly very high (near 100 percent) level of performance on them. CMS believes including these measures would have undesirable effects in the calculation of hospitals’ performance scores and could lead to unintended clinical consequences, such as inappropriate delivery of a measured service to some patients or inappropriate exclusions of some patients from the measure denominator to increase the resulting rate.

The result is 17 clinical process of care measures and one HCAHPS<sup>1</sup> measure that would be used for the FY 2013 VBP payment determination:

#### *Clinical Process of Care Measures*

##### Acute myocardial infarction

AMI-2 – Aspirin prescribed at discharge

AMI-7a – Fibrinolytic therapy received within 30 minutes of hospital arrival

AMI-8a – Primary percutaneous coronary intervention (PCI) received within 90 minutes of hospital arrival

##### Heart failure

HF-1 – Written discharge instructions provided

HF-2 – Left ventricular systolic function evaluated

HF-3 – Prescription at discharge of angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction

##### Pneumonia

PN-2 – Pneumococcal vaccination screened and provided if indicated

PN-3b – Blood cultures performed in the ED prior to initial antibiotic received in hospital

PN-6 – Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients

PN-7 – Influenza vaccination screened and provided if indicated

##### Healthcare-associated infections

SCIP-Inf-1 – Prophylactic antibiotic received within one hour prior to surgical incision

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<sup>1</sup> CMS proposes to create one HCAHPS measure by equally weighting and combining a hospital’s scores on the following eight dimensions of the HCAHPS survey: Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, Pain Management, Communication about Medicines, Cleanliness and Quietness of Hospital Environment, Discharge Information, and Overall Rating of Hospital.

SCIP-Inf-2 – Prophylactic antibiotic selection for surgical patients

SCIP-Inf-3 – Prophylactic antibiotics discontinued within 24 hours after surgery end time

SCIP-Inf-4 – Cardiac surgery patients with controlled 6AM postoperative serum glucose

*Surgeries*

SCIP-Card-2 – Surgery patients on a beta blocker prior to arrival that received a beta blocker during the perioperative period

SCIP-VTE-1 – Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered

SCIP-VTE-2 – Surgery patients who received appropriate VTE prophylaxis within 24 hours prior to surgery to 24 hours after surgery

*Patient experience measures*

Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS)

For FY 2014, CMS proposes to add the following outcome measures to the VBP program:

- Three all-cause 30-day mortality rates for Medicare patients admitted with a diagnosis of AMI, heart failure, or pneumonia. These are currently displayed on Hospital Compare.
- Eight CMS-designed measures of hospital-acquired conditions (HACs), six AHRQ Patient Safety Indicators (PSIs), and three AHRQ Inpatient Quality Indicators (IQIs, in-hospital mortality rates):

*CMS Hospital-Acquired Condition (HAC) measures*

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stages III & IV
- Falls and trauma (includes: fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Vascular catheter-associated infections
- Catheter-associated urinary tract infection
- Manifestations of poor glycemic control

*AHRQ Patient Safety Indicators (PSIs)*

- PSI 06 – Iatrogenic pneumothorax, adult
- PSI 11 – Postoperative respiratory failure
- PSI 12 – Postoperative PE or DVT
- PSI 14 – Postoperative wound dehiscence
- PSI 15 – Accidental puncture or laceration
- PSI 90 – Complications/patient safety for selected indicators (composite)

AHRQ Inpatient Quality Indicators (IQIs)

- IQI 11 – Abdominal aortic aneurysm repair mortality rate (with or without volume)
- IQI 19 – Hip fracture mortality rate
- IQI 91 – Mortality for selected medical conditions (composite)

*Comments – Quality measures*

Concerning the overall number of measures, we urge CMS to remain vigilant in maintaining a reasonable number of performance measures for the program. As the number of measures grows, the administrative costs to hospitals and CMS also increase. The agency should carefully consider the administrative burden, as well as potential unintended effects on hospitals' decisions to allocate scarce clinical care resources, of adding numerous additional measures.

Concerning the types of quality measures used in the hospital VBP program, we note that our own analyses of hospital quality—both aggregate quality across all hospitals and in our “efficient provider” analysis of individual hospitals' performance—are based primarily on outcome measures, such as rates of in-hospital and 30-day mortality and readmissions. The Commission also supports the use of process measures to evaluate quality when there is evidence that the processes being measured increase the chances of positive patient outcomes.<sup>2</sup> Some published literature examining the relationship between hospitals' performance on Medicare's publicly reported process measures and mortality rates—either across hospitals<sup>3</sup> or over time<sup>4</sup>—has found that hospitals with better process measure performance tend to have better patient outcomes and vice versa. However, a growing body of literature suggests that at least some of the process measures currently used to measure hospital quality in Medicare capture only a small proportion of the variation in hospital mortality rates or have little or no association with aggregate mortality or readmission rates.<sup>5,6,7,8,9,10,11</sup>

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<sup>2</sup> Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>3</sup> Jha, A. K., E. J. Orav, Z. Li, et al. 2007. Concentration and quality of hospitals that care for elderly black patients. *Archives of Internal Medicine* 167, no. 11 (June 11): 1177–1182.

<sup>4</sup> Werner, R. M., and E. T. Bradlow. 2010. Public reporting on hospital process improvements is linked to better patient outcomes. *Health Affairs* 29, no. 7 (July): 1319–1324.

<sup>5</sup> Romley, J. A., A. B. Jena, and D. P. Goldman. 2011. Hospital spending and inpatient mortality: Evidence from California. *Annals of Internal Medicine* 154, no. 3 (February 1): 160–167.

<sup>6</sup> Nicholas, L. H., N. H. Osborne, J. D. Birkmeyer, et al. 2010. Hospital process compliance and surgical outcomes in Medicare beneficiaries. *Archives of Surgery* 145, no. 10 (October): 999–1004.

<sup>7</sup> Fonarow, G. C., and E. D. Peterson. 2009. Heart failure performance measures and outcomes: Real or illusory gains. *Journal of the American Medical Association* 302, no. 7 (August 19): 792–794.

<sup>8</sup> Ryan, A. M., J. F. Burgess, Jr., C. P. Tompkins, et al. 2009. The relationship between Medicare's process of care quality measures and mortality. *Inquiry* 46, no. 3 (Fall): 274–290.

<sup>9</sup> Fonarow, G. C., W. T. Abraham, N. M. Albert, et al. 2007. Association between performance measures and clinical outcomes for patients hospitalized with heart failure. *Journal of the American Medical Association* 297, no. 1 (January 3): 61–70.

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*Use of CMS 30-day mortality rates and AHRQ Inpatient Quality Indicators* – Some quality experts have argued that process measures should be given priority because, in contrast to outcome measures, they provide more actionable information for quality improvement. However, that argument is weak if the process measures bear little or no relationship to the desired outcomes of care. Given the growing literature referred to above, and the reality that some process measures also may raise issues of appropriateness for the patient populations served by Medicare (e.g., process measures not designed for older patients with multiple chronic conditions), we urge CMS to focus primarily on patient outcome measures. Accordingly, we support CMS’s proposal to include the AMI, heart failure, and pneumonia 30-day mortality rate measures and the selected AHRQ Inpatient Quality Indicators (i.e., in-hospital mortality rate measures) in the hospital VBP program as soon as possible.

However, we also are concerned that all of the mortality rates upon which hospitals are scored are as statistically reliable as possible; that is, that the observed differences in hospitals’ rates represent real differences in health outcomes, and are not due to random statistical variation from a low number of observations. Our experience analyzing 30-day mortality rates and the AHRQ IQIs indicates that a longer observation period increases the number of IPSS hospitals for which the rates are statistically reliable. Given the imperative to include these important outcome measures in the hospital VBP program as soon as possible, CMS’s proposal to initially use an 18-month performance period for the 30-day mortality rate measures, which will allow their use in calculating the FY 2014 VBP incentive payments, seems reasonable. Before issuing the proposed rule for the FY 2014 hospital VBP program, CMS should carefully evaluate the statistical reliability of hospitals’ performance scores on the 30-day mortality rates and AHRQ IQIs. This analysis should examine how much statistical reliability increases—that is, how much is random variation in scores reduced, especially for smaller IPSS hospitals—as the length of the performance period increases. The results of this analysis should be presented in the proposed rule for the FY 2014 program.

Another approach CMS could consider is using a broader 30-day mortality rate measure, for example, a 30-day mortality rate that captures all Medicare patients admitted to the hospital, not just those admitted with diagnoses of AMI, heart failure, or pneumonia. While those three diagnoses are among the most common for Medicare inpatients, they represented only about 8.5 percent of total Medicare inpatient discharges and spending in 2009. A transparently developed and appropriately vetted 30-day mortality rate measure that included all or most hospital inpatient admissions would increase the breadth of performance reflected in the measure, as in the proposed AHRQ IQI composite of in-hospital mortality for selected medical conditions. We note that developing appropriate risk adjustment for a hospital-wide mortality measure is

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<sup>10</sup> Bradley, E. H., J. Herrin, B. Elbel, et al. 2006. Hospital quality for acute myocardial infarction: Correlation among process measures and relationship with short-term mortality. *Journal of the American Medical Association* 296, no. 1 (July 5): 72–78.

<sup>11</sup> Werner, R. M., and E. T. Bradlow. 2006. Relationship between Medicare’s hospital compare performance measures and mortality rates. *Journal of the American Medical Association* 296, no. 22 (December 13): 2694–2702.

particularly challenging, and if CMS evaluates the feasibility of such a measure for Medicare in the future, we urge the agency to carefully consider the findings of recent research that assessed four existing methods to calculate hospital-wide mortality.<sup>12</sup>

*Use of CMS Hospital-Acquired Conditions and AHRQ Patient Safety Indicators* – The Commission is concerned about recently published studies indicating that rates of hospital-acquired conditions (HACs) and hospital patient safety incidents remain unnecessarily high and that progress in improving patient safety in hospitals has been slow.<sup>13,14,15</sup> We note that the Congress (in section 3008 of the PPACA) authorized the Secretary to implement a policy beginning in FY 2015 that will reduce DRG payments by 1 percent for IPPS hospitals that are in the top quartile of rates of HACs across all IPPS hospitals. We do not think HAC measures that will be used in the forthcoming HAC payment penalty policy should also be included in the hospital VBP program. To the extent that the AHRQ PSI measures will be included in the definition of HACs for the HAC payment policy, they also should not be included in the hospital VBP program, but they are important measures that should be included in one or the other.

*Summary of proposed rule – Efficiency measures*

For FY 2014 or a subsequent year, PPACA requires CMS to ensure that the measures selected for the hospital VBP program include efficiency measures, including measures of Medicare spending per beneficiary. The statute also requires that “such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate” (section 1886(o)(2)(B)(ii) as added by section 3001 of PPACA).

CMS solicits comments as to what services should be included and what should be excluded in the required calculation of Medicare spending per beneficiary. For example, in addition to base DRG payments, should the calculation include outlier payments and/or Part B payments for services furnished during an inpatient hospital stay? Should it include other Part A or Part B payments for services received by a beneficiary during some time window before admission and/or after discharge? The agency also seeks comments on what, if any, type(s) of hospital segmentation or adjustments should be considered. Lastly, CMS states it is considering different approaches for measuring internal hospital efficiency, such as hospital spending per admission determined using cost reports or other sources. CMS seeks comment on this and other approaches for measuring internal hospital efficiency.

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<sup>12</sup> Shahian, D. M., R. E. Wolf, L. I. Iezonni, et al. 2010. Variability in the measurement of hospital-wide mortality rates. *New England Journal of Medicine* 363, no. 26 (December 23): 2530–2539.

<sup>13</sup> Eber, M. R., R. Laxminarayan, E. N. Perencevich, and A. Malani. 2010. Clinical and economic outcomes attributable to health care-associated sepsis and pneumonia. *Archives of Internal Medicine* 170, no. 4 (February 22): 347–353.

<sup>14</sup> Landrigan, C. P., G. J. Parry, C. B. Bones, et al. 2010. Temporal trends in rates of patient harm resulting from medical care. *New England Journal of Medicine* 363, no. 22 (November 25): 2124–2134.

<sup>15</sup> Office of Inspector General. 2010. Adverse events in hospitals: National incidence among Medicare beneficiaries. Report no. OEI-06-09-00090. Washington, DC: OIG.

*Comments – Efficiency measures*

The Commission encourages the Secretary to consider efficiency measures for the VBP program that provide incentives for hospitals to avoid unnecessary inpatient admissions and control spending on an episode level rather than focusing exclusively on spending per admission. The inpatient prospective payment system currently incorporates incentives for hospitals to reduce spending per admission by paying a set amount based on the patient's Medicare severity – diagnostic related group (MS-DRG). Rather than duplicate incentives that already exist for reducing costs during the hospital stay, new efficiency measure(s) to be developed for the VBP program could incentivize hospitals to reduce the volume of unnecessary admissions. For example, hospitals might be incentivized to reduce the volume of potentially preventable admissions in a given year. In addition, new efficiency measures could incentivize hospitals to control spending for the entire episode of a Medicare beneficiary's care around the admission including, for example, related Part B spending on post-acute care.

**Methodology for calculating the total performance score (section II.E.)**

*Summary of proposed rule*

The PPACA provision authorizing the hospital VBP program directs that each participating hospital's performance score on each measure must be evaluated based on the greater of an achievement score or an improvement score. Whether computing the achievement or improvement score, CMS will calculate two key values for each clinical process of care and (when they are introduced) outcome measure: the "achievement threshold," equal to the median of all hospital scores on the measure during the baseline period; and the "benchmark," equal to the mean of the top decile of all hospital scores on the measure during the baseline period. To calculate a hospital's achievement score on a measure, CMS would calculate where the hospital's performance on the measure fell between the achievement threshold and the national benchmark, and award the hospital between 0 and 10 points based on where its performance falls in that range. The improvement score will be determined by comparing the hospital's performance on the measure to its performance on that measure in the baseline period, with a possible point range of 0 to 9 points. The hospital will receive the number of points for the measure based on whichever method (achievement or improvement) yields the most points.

After a hospital has been awarded points for each measure, CMS proposes to calculate a Total Performance Score for each hospital by summing the points for all of the measures within each measure domain (for example, the domains in FY 2013 would be clinical process of care and patient experience); multiplying the domain score total by the percentage weight for the domain; and adding the weighted scores for each domain.

A critical piece of the total performance score calculation is the weight given to each of the measure domains. For FY 2013, CMS proposes a weight of 70 percent for the clinical process of care domain and 30 percent for the patient experience of care domain. These weights would be

adjusted in FY 2014 and beyond when an outcome measure domain is added. CMS seeks public comment on what weight it would be appropriate to assign to the outcome measure domain in FY 2014 and after.

#### *Comments*

*Proposed method for setting a measure's achievement threshold and benchmark* – We generally support the agency's proposed definitions of the achievement threshold (the median of all hospitals' rates) and the benchmark (the mean of the top decile of all hospitals' rates). However, we also note that CMS, in its 2007 report to the Congress on the design of a hospital VBP program, pointed out a circumstance when the approach in the proposed rule would be problematic: when the distribution of hospitals' performance on a measure is concentrated at very high values. In that case, the range between the achievement threshold and the benchmark is only a few percentage points with the achievement threshold (i.e., the median for the entire distribution) well over 90 percent and benchmark (the mean of the top decile) is at or near 100 percent. In effect, these are "topped-out" measures because the performance range as defined by the formula in the proposed rule is compressed near the maximum performance rate of 100 percent.

In the proposed rule, CMS proposes to deal with "topped-out" measures by excluding them in the VBP program. But in its 2007 report to the Congress on hospital VBP, the agency noted that some topped-out measures may still be considered valid indicators of appropriate care and should remain in the program as long as it is clinically beneficial for hospitals to focus on them. If they are included, CMS also discussed in the 2007 report that it would need a different way of defining the achievement range and benchmark because the usual approach would yield a very compressed range between the achievement threshold and benchmark. CMS suggested using high absolute performance standards for these measures, such as setting the achievement threshold at 60 percent and the benchmark at 90 percent. This approach would increase the size of the performance range, thereby allowing more hospitals to potentially earn performance points, while maintaining a high level for the benchmark performance needed to achieve the maximum possible number of points.

This is an urgent issue for the first year of the VBP program because most of the clinical process measures that CMS proposes to use in the program have these very narrow achievement ranges (although CMS does not propose to exclude them as "topped-out" measures). Based on our analysis of the proposed process measures using the December 2010 Hospital Compare database, 16 of the 17 clinical process of care measures proposed for the FY 2013 VBP program have medians (which would be their achievement thresholds under the VBP program) of 90 percent or greater. Instead of excluding these measures—which would leave almost no clinical process of care measures for use in FY 2013—we urge CMS to reconsider using the approach to scoring these "topped out" measures as discussed in the 2007 report to the Congress. As new quality measures come into use in the future, these "topped out" measures could be retired or weighted less in the calculation of hospitals' overall performance scores.

*Domain weights* – The Commission maintains that the quality of care provided to Medicare beneficiaries should be evaluated across multiple domains, including outcomes, clinical processes of care, patient experience, and structural measures. Performance measurement should focus predominantly on areas of care delivery where it is more difficult for beneficiaries and other laypersons to directly assess quality of care, which means that relatively more weight should be devoted to measures of clinical outcomes and care processes, and somewhat less on patient experience measures and structural measures (which assess the presence of infrastructure related to higher quality care, but not necessarily its use).

In FY 2014, when outcome measures are added to the VBP program, the outcome measure domain should be given significant weight, equal to or greater than the clinical process of care domain. For example, in FY 2014 CMS could give the outcome and process domains equal weights of 45 percent and correspondingly reduce the weights given to the patient experience and structural measures (for example, 5 percent each or 10 percent for the patient experience domain if no structural measures are included). CMS should consider gradually increasing the weight of the outcome measure domain over time as additional outcome measures are added.

#### **Applicability of the VBP program to hospitals with low numbers of cases or few applicable measures (section II.F.)**

##### *Summary of proposed rule*

As required by the authorizing statute, the hospital VBP program will apply only to hospitals defined as a “subsection (d) hospital,” or in other words hospitals that are reimbursed by Medicare under the inpatient prospective payment system (IPPS). The VBP program will not apply to psychiatric, rehabilitation, long term care, children’s, and cancer hospitals, nor will it apply to facilities designated as Critical Access Hospitals (CAHs). The law directs CMS to implement a three-year demonstration VBP program for CAHs by March 20, 2012.

For IPPS hospitals, CMS proposes to exclude from the VBP program altogether any hospital to which less than four of the proposed measures apply or that reports fewer than 100 HCAHPS surveys during the performance period. CMS also proposes to exclude from a participating hospital’s total performance score calculation any measures on which the hospital reports using fewer than 10 cases. CMS seeks comments on its proposals regarding the minimum numbers of cases and measures that would be required for hospitals’ inclusion in the program. CMS notes that any hospital excluded altogether from the VBP program also will be exempt from having its base operating DRG payments reduced to contribute to the VBP incentive pool, which the agency is concerned could create a perverse incentive for some hospitals to not report on certain measures or even stop participating in the quality reporting program completely, if the hospital concluded it would be financially better off doing so.

*Comments*

The Commission recognizes that certain types of hospitals—including hospitals that are small, located in rural areas, and/or primarily focused on stabilizing patients and then transferring them to larger hospitals—will report small numbers of cases for the calculation of some of the proposed performance measures. CMS notes in the proposed rule that the resulting performance scores reported for these hospitals could vary substantially from period to period solely based on random statistical variation, which could reward or punish these hospitals for changes in their performance scores that are possibly unrelated to the hospital's actual behavior.

In these cases, the Commission suggests using performance data from multiple years to increase the number of observations in the performance measure calculations and therefore their statistical reliability. CMS could also consider using a different set of performance measures for these hospitals in the future, including measures that are specific to the kinds of services more typically provided by smaller, particularly rural, hospitals, such as measures of care processes involved in stabilizing and safely transferring patients to larger treatment facilities. Lastly, CMS could consider applying different domain weighting when calculating smaller hospitals' VBP scores, for example decreasing the weight placed on measures that have lower statistical reliability.

**The exchange function (section II.G.)**

*Summary of proposed rule*

The last step in the calculation of each hospital's VBP program incentive is to translate each hospital's total performance score into a value-based incentive payment percentage. CMS proposes to use a linear exchange function for at least the first year of the VBP program. CMS notes that the proposed linear exchange function would provide the same marginal incentives to both lower- and higher-performing hospitals. CMS invites comments on whether another form of the exchange function should be used, for example a curve that would increase incentive payments to higher-performing hospitals at the expense of lower-performing hospitals or vice versa.

*Comments*

We support CMS's proposal to use a linear exchange function for the initial years of the VBP program. Until CMS possesses trend data to analyze how participating hospitals with higher or lower performance scores responded to the program's performance incentives, it is prudent to use a simple exchange function that creates equal incentives for high- and low-performing hospitals. Over time, CMS could consider changing the exchange function to create stronger incentives (i.e., potentially relatively larger VBP bonus payments) for low-performing hospitals to increase their quality of care. Recent research based on data from the Medicare Hospital Quality Incentive Demonstration, as well as a data analysis and literature review in our June 2010 report to the Congress, suggest that improving the quality of care among the lowest-

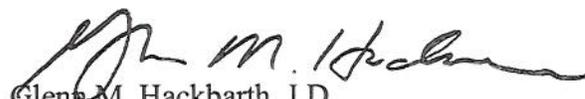
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performing providers would help to address persistent racial and socioeconomic disparities in care.<sup>16,17</sup>

### *Conclusion*

The Commission appreciates the opportunity to comment on the proposed regulations for implementing this significant change in Medicare payment policy: rewarding the value of care provided rather than the volume of services delivered. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Glenn M. Hackbarth, J.D.  
Chairman

GMH/jr/w

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<sup>16</sup> Jha, A.K., E. J. Orav, and A. M. Epstein. 2010. The effect of financial incentives on hospitals that serve poor patients. *Annals of Internal Medicine* 153, no. 5 (September 7): 299-306.

<sup>17</sup> Medicare Payment Advisory Commission. 2010. *Report to the Congress: Aligning incentives in Medicare*. Washington, DC: MedPAC.