PRE-RULEMAKING COMMENTS ON IMPLEMENTATION OF VALUE-BASED PURCHASING (SEC. 3001 OF THE AFFORDABLE CARE ACT)

The Society for Healthcare Epidemiology of America (SHEA) strongly supports policies that link payment to quality outcomes and performance and has provided such comments to CMS related to the IPPS. SHEA appreciates the opportunity to offer these comments on issues pertaining to implementation of Section 3001 of the Affordable Care Act (ACA), value-based purchasing (VBP) for inpatient hospital services prior to the issue of a notice of proposed rulemaking.

Notice and comment rulemaking

The ACA requires that the VBP program be implemented through notice and comment rulemaking and involve stakeholder consultation. SHEA appreciates the initial steps taken by CMS to get stakeholder input. As would be expected, this initial input has not involved the important technical details that will determine the distribution and amount of VBP incentives, including how the performance standards will be established. We strongly recommend that CMS engage in full notice and comment rulemaking and not implement the VBP program using an interim final rule. It is critical that additional stakeholder input be garnered once the technical details are available.

Acceptable period of time for performance period

The ACA requires that performance standards be announced 60 days before the start of each performance measurement period. Because the VBP program will begin to affect inpatient hospital payments in FY 2013, designating the initial performance period poses some challenges. For example, it is possible that the performance period will need to end by calendar year December 31, 2011 to allow time for hospital reporting, validation, notification of VBP scores, and appeals prior to October 1, 2012. SHEA offers these thoughts and recommendations:

- In view of the short implementation timeframe, the requirement of notice and comment rulemaking, and the requirement for 60 days advance notice prior to the start of the performance period, the initial performance period may need to be less than a full year in duration. We believe that the initial performance period should not be less than six months duration.

- Considering seasonal variation, performance measures should compare performance levels for comparable time periods in the current and prior years.

- SHEA understands the 60-day notice requirement to mean that hospitals will know all of the standards and technical requirements on which their performance will be assessed before the performance period is initiated. They will know the performance score they must achieve to earn back their full VBP set aside and

they will know how their VBP incentive will be calculated from their performance score. These standards and methodologies must be fixed before the performance period begins so that hospitals know exactly what is at stake and have a fair chance to earn back their VBP set aside.

Performance scoring method

The ACA requires that hospitals' performance be assessed based on a single composite measure. To implement this requirement, SHEA recommends that CMS calculate separate composite scores for each specific patient condition, such as heart attack, heart failure, pneumonia, catheter-associated bloodstream or surgical infection, and that these separate condition scores be combined into an overall composite score based on a case-weighted average using the number of cases in each condition. The ACA requires that both performance and attainment be considered in determining a hospital's composite score. SHEA recommends that each hospital's composite score be determined by whichever yields the higher value, performance improvement or attainment.

Determining VBP payments based on composite score

Some schemes for determining VBP incentive payments would provide that hospitals below a certain threshold of performance would not be eligible for *any* VBP incentive. SHEA strongly opposes such schemes and believes that *every* hospital should be eligible for an incentive payment based on its level of performance. A hospital with low performance likely would receive only a small incentive payment, but its eligibility for even a small payment provides an incentive for the hospital to improve its performance. If hospitals with performance scores below a prescribed performance standard cannot earn any VBP incentive, hospitals well below the standard might conclude that the standard was unachievable and not invest much effort to improve their performance. The incentive allocation system should be structured so that all hospitals are eligible for some financial incentive that would vary based on their performance and improvement. Although all hospitals should be eligible for incentive payments, SHEA believes that hospitals with a higher performance score should receive a higher VBP incentive payment.

SHEA also strongly believes that performance thresholds should be established at a level which hospitals reasonably could be expected to achieve. The "full-incentive performance standard" should be set so that every hospital has a realistic chance, through attainment or improvement, to earn back its entire VBP set aside. This is especially important in the early years of the VBP program.

Distributing unallocated VBP program funds

Although every hospital should have a reasonable chance to earn back its entire VBP set aside, not every hospital will achieve the necessary level of attainment or improvement. The ACA requires that all funds set aside for the VBP program be distributed to hospitals

in the year that they are set aside. SHEA recommends that the unallocated funds be distributed to all hospitals participating in the VBP program based on their level of performance. Hospitals with superior performance should be rewarded with greater payments using these unallocated funds. SHEA notes that these funds provide an opportunity for hospitals to earn a VBP incentive payment that is more than just earning back their set aside amount. This constitutes a true incentive for continuous quality improvement at the upper end of performance.

Method used to distribute incentive payments

VBP program incentives could be distributed to hospitals in several ways, each of which may have a different effect on hospitals' abilities to use the payments to implement quality improvement activities. Payments could be distributed with hospital reimbursements made for each eligible patient. Through this distribution method, hospitals would receive a portion of their overall pay-for-performance incentives with each Medicare claim. Any remaining payments should be provided during a reconciliation process at the end of the fiscal year.

Choice of measures

The ACA requires that the initial measures selected for the VBP program be chosen from measures currently in the inpatient quality reporting program. SHEA strongly believes that all future measures used for reporting and for the VBP program should be endorsed by the NQF and recommended for use in VBP by stakeholders like the hospital quality alliance. In addition, all VBP measures should be reported for at least a year before they are used for payment purposes.

Weighting performance measures

To calculate condition scores from the various performance measures applicable to each condition, SHEA recommends that each measure be weighted equally. In the future, when outcomes measures are fully developed and adequately risk-adjusted, CMS could consider an alternative weighting scheme that might assign equal weight to a composite of clinical process measures and to a composite of risk-adjusted outcome measures, thus in effect weighting outcomes fifty percent. SHEA believes that some outcomes measures are not sufficiently well developed and appropriately risk-adjusted at this time to be given this higher weight. Stakeholders should be consulted and changes proposed through notice and comment rulemaking before moving to different weighting schemes.

Concerning the appropriate weighting for patient assessment of care (HCAHPS), SHEA recommends that HCAHPS not be weighted more than 20 percent and, therefore, clinical measures not less than 80 percent.

Data validation.

SHEA supports the change from the current chart validation process that requires five records per quarter from every hospital to 12 charts per quarter from a random sample of 800 hospitals with a minimum of 100 total charts. We believe that this more targeted approach will assure that all topic areas are validated. While it increases the number of charts required, it reduce the number of times hospitals have to provide charts. We encourage that the results of these validations be shared with all the hospitals, not just those sampled, including educational and data element clarification. The National Healthcare Safety Network (NHSN) measures (eg, CLABSI and SSI) that are likely to be selected as VBP measures will continue using current validation methods.

CMS will assess the accuracy of the hospital's measure rate, as opposed to the accuracy of the individual data elements. SHEA believes that it is appropriate to focus on the hospital's measure rate, because this captures the information that is truly important to patient care. For data validation in the current program, there have been several instances in which a mismatch between single data elements unrelated to the quality of care provided by a hospital, such as the patient's birth date, have caused hospitals to fail validation. Validating the hospital's measure rate should eliminate hospitals failing validation due to an error in a field unrelated to patient care. Electronic NHSN design with its heavy use of force fields plus quality review of the data by the CDC before transfer to CMS should also minimize this type of error.

In addition, to pass validation, CMS is requiring that hospitals meet a minimum of 75 percent reliability from the chart validation instead of the 80 percent match rate currently used. SHEA supports setting a slightly lower validation threshold for all measures, for the beginning years of the new validation process as hospitals and CMS gain experience with the new system.

SHEA urges CMS to refine the validation selection process so that hospitals selected for validation in one year are not eligible for selection again until two years later. Alternatively, CMS could ensure that no hospital is selected more than two times within a five-year period. This will help make certain that any particular hospital is not disproportionately burdened by the selection process. Additionally, CMS should consider allowing hospitals that pass validation with a very high score to receive a "pass" from the validation process for several years. Such a policy will encourage hospitals to ensure their data are as accurate as possible and reward those hospitals with high accuracy rates. Conversely, targeting consistently high measure rates, relative to national averages, would inappropriately misdirect validation to the high-performing hospitals.

Relationship of VBP to inpatient Quality Reporting Program

CMS should clarify the relationship between the VBP program and the existing penalty for not reporting quality measures under the inpatient Quality Reporting Program. The ACA provides that certain hospitals would be excluded from the VBP program, including those that fail to report quality measures under the quality reporting program; those that

have been cited by the Secretary for deficiencies that posed immediate jeopardy to the health or safety of patients during the performance period; and hospitals for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply. The ACA does not repeal the quality reporting program and the associated penalty for not reporting satisfactorily, so there is confusion about how this requirement interfaces with the VBP program. SHEA urges CMS to clarify that hospitals which fail to report satisfactorily and thus are subject to the quality reporting penalty are not also penalized by being subject to the VBP reduction. It would be unfair to apply the VBP set aside to these hospitals since they are not eligible for VBP incentive payments and already have been assessed the quality reporting penalty.

SHEA also believes that hospitals lacking a minimum number of patients or conditions for a VBP performance score should not be penalized. These hospitals should be paid the full MS-DRG payment.