



Arizona Hospital and Healthcare Association

Submitted Electronically

August 30, 2011

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

RE: CMS-1525-P: Proposed Rule Regarding Medicare Program--Proposed Changes to the Hospital Outpatient Prospective Payment System, Hospital Inpatient Value-Based Purchasing (VBP) Program; Federal Register Volume 76, No. 137, July 18, 2011. RIN # 0938-AQ26.

Dear Dr. Berwick:

On behalf of our 102 member hospitals and healthcare organizations, the Arizona Hospital and Healthcare Association (AzHHA) welcomes the opportunity to respond to the Center for Medicare & Medicaid Services' proposed rule regarding the Hospital Outpatient Prospective Payment System, and Hospital Inpatient Value-Based Purchasing (VBP) Program; Federal Register Volume 76, No. 137, July 18, 2011. RIN # 0938-AQ26.

Direct Supervision of Outpatient Therapeutic Services

Comment: AzHHA appreciates steps that CMS has taken to address hospital issues and concerns around its direct supervision policy. We are pleased with the extended delay in enforcement of direct supervision requirements in CAHs and small rural PPS hospitals, and continue to believe that there are many procedures that can be, and are, safely furnished in hospital outpatient departments under the general supervision of a physician. We are encouraged by the proposed implementation of an independent review process that will be used to consider and revise supervision levels for certain outpatient therapeutic services. However, we are concerned that the independent review process, as designed, does not allow for formal public notice and comment on CMS' decisions. This proposal has the potential to unfairly represent the interests of small rural PPS hospitals, and could even result in more burdensome supervision requirements for services without justification.

Recommendation: We urge CMS to include provisions for formal public notice and comment in the design of their rules regarding the supervision of outpatient therapeutic services.

Wage Index Rural Floor

Comment: In the proposed rule, CMS raises concerns about hospital actions involving the inpatient PPS wage index rural floor that have resulted in significant wage index disparities. Since the law does not require use of the inpatient PPS wage index in the outpatient PPS, the agency is considering alternative wage index proposals and seeks public comment on the various options it is considering for implementation.

AzHHA believes the area wage index is seriously flawed in many respects. It is highly volatile from year to year, is self-perpetuating (in that hospitals with low wage indices are unable to increase wages to become competitive in the labor market), and is based on unrealistic geographic boundaries. These fundamental problems warrant a comprehensive reevaluation and redesign of a system that CMS itself acknowledges is burdensome and of questionable integrity.

As you are aware, the hospital wage index has generated much discussion and activity in recent months. In April, CMS issued a report by its contractor, Acumen, on an alternative wage index methodology and solicited public comments. In June, the Institute of Medicine (IOM) issued recommendations for CMS on the wage index and the geographic practice cost index. The IOM took an entirely different approach from Acumen, and consequently its recommendations differ significantly. Also, the IOM announced that it will issue follow-up reports to its June report. In addition, the *Affordable Care Act (ACA)* requires that CMS provide a plan to Congress by December 31, 2011 to comprehensively reform the Medicare hospital wage index.

In recognition of the substantial challenges entailed in revising such an imperfect wage index, the American Hospital Association Board of Trustees created a Wage Index Task Force in July 2011 to further examine the issue and analyze reports that the IOM and CMS are required to complete. As part of the Task Force's deliberations, it plans to consider the rural floor issue.

Recommendation: We urge CMS to provide more detail on the various options contained in the proposed rule to address its concerns about the rural floor. In particular, one option CMS sets forth that appears to hold promise is to adopt a decision rule for when the rural floor should not be applied in the outpatient PPS because it will have a disproportionate impact. CMS should provide more information on this option in the final rule, including what decision rule it would implement, what it would consider a disproportionate impact, and an impact analysis. Such details would greatly inform the Task Force's deliberations and leave its members better able to fully consider this issue.

Value-Based Purchasing (VBP)

Comment: The ACA limits the measures that can be used under the VBP program to measures that have been included on the Hospital Compare website for at least one year prior to the beginning of the measure's performance period for the VBP program. In previous rulemaking, CMS has adopted an efficiency measure and two Agency for Healthcare Research and Quality (AHRQ) composite measures for use in the VBP program. Also in previous rulemaking, CMS has put forward the following starting dates for the performance periods related to these measures:

- Efficiency measure (adopted in 2012 IPPS final rule): May 15, 2012.
- AHRQ Composite measures (proposed in 2012 OPSS proposed rule): March 3, 2012.

Based on these performance periods, the efficiency measure must have been posted on the Hospital Compare Web site by at least May 15, 2011; the AHRQ Composite measures by at least March 3, 2011. Currently, only brief and vague definitions for these measures exist in the "Glossary" section of the Hospital Compare website. No data for these measures is available, nor has CMS proposed a timeline for the actual and true posting of these measures to the Hospital Compare website. Posting only "definitions" of measures to Hospital Compare rather than the measure's full content and data elements does not constitute meaningful notification of the measure to hospitals, and does not comply with the spirit and intent of the law.

Recommendation: We urge CMS to rescind the use of the efficiency measure and AHRQ Composite measure until the measures are actually made public on the Hospital Compare Website. Once the measures are made public, then CMS, through another rulemaking process, should establish VBP performance periods for these measures.

Comment: CMS is placing half of the total VBP weight on two new domains, neither of which are currently reported on Hospital Compare, nor have they been fully vetted by the industry. In doing this, CMS has significantly reduced the weight for the most widely accepted and used domain – Process – while retaining a high 30 percent weight for the Patient Satisfaction domain, which is the most subjective and a significant driver of lower hospital VBP scores.

Recommendation: AzHHA urges CMS to revise the domain weights established in the 2012 OPSS proposed rule for the FFY 2014 VBP program to reflect the use of a revised set of measures that comply with the notification requirements set in law. The domains and weights should be revised to reflect only those measures that meet the true intent of

the mandate (i.e. public posting of measures on Hospital Compare). Newly adopted domains should be phased in at lower weights in order to allow the industry to accommodate the new measures, reduce wild swings in VBP scores, and create a more stable program.

Comment: The VBP measures previously adopted and those proposed by CMS do not meet the full transparency requirements of the ACA for public posting on Hospital Compare. The timing and format of the measures posted on Hospital Compare do not allow hospitals to adequately measure their current standing/performance for VBP. For example, CMS proposes a nine-month baseline and performance period for the process and HCAHPS measures, but the data on Hospital Compare reflects 12-month time periods. Hospitals cannot use this data to assess their most current nine-month performance. Similarly, the outcomes measures are also not currently posted for the same time periods that will be used in VBP.

Recommendation: We recommend that CMS post the scores for those measures that will be included in VBP in the same format and time period as will be used in the program.

Comment: The minimum case size for the mortality measures is too small. CMS is contradicting its own standards for Hospital Compare, where 25 cases are the minimum. We surmise that this is the reason CMS displays data for a three-year time period – in order to compile a larger set of data for small hospitals, where the case size is too small to provide statistical significance. The minimum case size for the AHRQ composite measures and Healthcare Associated Conditions (HAC) is also too small. It is highly unlikely that a case size of three will yield meaningful quality statistics. Particularly since the industry cannot estimate what the rates will look like for small hospitals, it is impossible to tell whether the law of small numbers will have a discriminatory impact in the measure. AzHHA is concerned that hospitals with smaller numbers of cases may be adversely impacted.

Recommendation: CMS should either increase the minimum case size to 25, or release data for 12-month time periods with the 10 case minimum for the industry to analyze before adopting these measures.

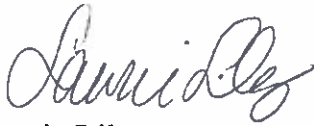
Comment: CMS has chosen to release details of the VBP program in a piecemeal, disjointed fashion. This approach creates information gaps, and makes it difficult for the industry to track changes and comment effectively on rulemaking proposals. While we appreciate CMS' enthusiasm and effort in communicating VBP program parameters, and adding measures as quickly as possible, we are concerned that the current approach may yield unintended consequences as it does not provide one comprehensive, cohesive picture of the program.

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Recommendation: We urge CMS to establish a set rulemaking cycle for the VBP program, and include all facets of program documentation and development within the context of a defined program.

We appreciate your consideration of our recommendations. If you have any questions, please contact me or Tanie Sherman, Director of Regulatory Advocacy, at (602) 445-4303 or at tsherman@azhha.org.

Sincerely,

A handwritten signature in cursive script, appearing to read "Laurie Liles".

Laurie Liles
President and Chief Executive Officer