

January 18th, 2007

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(via e-mail to *cmshospitalVBP@cms.hhs.gov*)

Subject: Comments re Medicare Hospital Value-Based Purchasing

Dear Ms. Phillips:

These comments are submitted on behalf of the Rural Wisconsin Health Cooperative (RWHC). RWHC, started in 1979, is owned and operated by thirty-one rural hospitals (all are under a hundred beds and include both Critical Access and Prospective Payment System Hospitals). In addition, four regional tertiary systems with an interest in rural health, are non-voting affiliates. RWHC works to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health.

We are responding to the following request from the Federal Register (Vol. 71, No. 226) on Friday, November 24, 2006 starting on page 67876:

“Section 5001(b) of The Deficit Reduction Act (DRA) of 2005, specifies that CMS develop a plan to implement a Value-Based Purchasing (VBP) Program for payments under the Medicare program for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (the Act)) beginning with fiscal year (FY) 2009. Congress specified that the ‘plan’ include consideration of the following issues:

- The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings.
- The reporting, collection, and validation of quality data.
- The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments.
- The disclosure of information on hospital performance.”

“In developing the plan, we must consult with relevant affected parties and consider experience with demonstrations that are relevant to the value-based purchasing program. CMS has created a workgroup that is charged with developing the VBP Plan for Medicare hospital services provided by subsection (d) hospitals.”

“The Workgroup is organized into four subgroups to address each of the required planning issues:

- (1) Measures;
- (2) data collection and validation;
- (3) incentive structure;
- (4) and public reporting.”

“The CMS Workgroup is charged with preparing a set of design options, narrowing the set of design options to prepare a draft plan, and preparing a report on the plan for implementing VBP for Medicare hospital services which will be provided to Congress as required under section 5001(b)(3) of the DRA.”

RWHC General Comments

We recognize that this initiative does not apply to Critical Access Hospitals but we also know that in the future there is some likelihood that Congress may mandate that CAHs also be subject to “value-based purchasing.” If this occurs, we believe that the decisions made at this time with this program for lower volume subsection (d) hospitals may be subsequently applied to all lower volume rural hospitals, including CAHs. Consequently the potential impact of this Plan beyond the current Congressional mandate should be taken very seriously.

In any event, we would strongly suggest that the unique technical problems relevant to the implementation of value-based purchasing for rural and lower volume hospitals requires consideration of their unique context as a key, core question, not merely as an addendum. For this to happen, we strongly recommend that the CMS Workgroup convene a subset of its members to specifically address the technical issues relevant to rural and lower volume hospitals.

Our experience with new program or policy development has been that contextual issues relevant to individual providers serving a relatively small number of Medicare beneficiaries are at high risk of being glossed over as “issues on the margin” that can be “dealt with later.” That was, in part, what happened with the startup of the Prospective Payment System and rural health spent over twenty years, “dealing with it later.”

In addition, we would like to reinforce for your consideration the following general findings from *The Implementation of Pay-For-Performance in Rural Hospitals: Lessons from the Hospital Quality Incentive Demonstration Project* by Walter Gregg, MA, MPH, University of Minnesota, Ira Moscovice, PhD, University of Minnesota and Denise Remus, PhD, RN, Premier, published by the Upper Midwest Rural Health Research Center in September, 2006.

- “The influence of bonus payments incentives is limited for hospitals with low inpatient volumes. A large number of rural hospitals that may participate in future P4P programs will be low inpatient volume facilities.”
- “Non-financial incentives can make a difference, especially for physicians and nurses who are more motivated by feedback on the quality of care they are providing to their patients. The close-knit community culture of many small, remote rural communities may work to the advantage of rural hospitals through more selective and effective peer influence.”
- “Physicians and nurses need feedback on the care they are providing. The more frequent, clear, and accurate the feedback, the more effective it will be in helping them improve their daily performance. The lack of information infrastructure, automated systems, and greater demand being made on the limited number of physicians available may be a disadvantage in rural hospitals.”
- “The provision of provider feedback can only foster performance improvements to the degree to which the necessary tools, education, and guidance are made available to reinforce and maintain the effort. The relative lack of resources for building education and guidance infrastructure in smaller rural hospitals will make the task much harder for freestanding rural hospitals compared to those in systems or urban facilities.”
- “Physician and nurse involvement is critical for successful participation in P4P programs. Difficulties recruiting and retaining physicians and nurses common to many small rural hospitals may undermine efforts to engage them in non-clinical direct care activities.”
- “Limited clinical staff will make it difficult to meet added staffing needs of P4P, especially in terms of nursing resources. Small rural hospitals can benefit from defined skill sets for quality management staff that maximize nursing time for direct patient care.”
- “Limited availability of pharmacists, phlebotomists and laboratory staff will add challenges to meeting critical timing and sequencing requirements of P4P initiatives.”
- “Limited capital reserves and access to capital markets of small rural hospitals will be a significant barrier to the adoption and implementation of the information technologies and infrastructure needed for P4P participation.”

RWHC Comments Re Measures

- The cacophony of voices and expectations both nationally and within states like Wisconsin are a major distraction; we are being pulled in too many different unaligned directions. A national consensus is needed sooner rather than later regarding the key metrics upon which hospitals with limited resources should focus under value-based purchasing schemes.
- The word “rural” is not mentioned in the “Medicare Hospital Value-Based Purchasing Plan Development Issues Paper” prepared for the January 17th CMS listening session. Nor did we see a discussion about how unique characteristics of local community populations such as health literacy, treatment compliance, percent uninsured, percent who smoke and other behaviors can affect certain measures in ways not captured by standard risk adjustment

mechanisms. In addition, some rural communities may expect more from their local hospital than distant urban hospital re waiting times, staff communication, etc. putting local hospitals at a relative disadvantage with certain measures.

- Hospital measures should be chosen, in part, that are more likely to get physician “buy-in” particularly in communities with smaller medical staff and no “physician champion.”
- From the *The Implementation of Pay-For-Performance in Rural Hospitals (TIPFPRH)* noted above. “Future P4P programs need to be relevant for small rural hospitals in the clinical areas targeted for performance improvement. Financial incentives based on a competitive or balanced-budget design will make it difficult for low performers to achieve program goals. Balancing incentives geared to meeting or exceeding defined performance thresholds with incentives designed to reward improvement regardless of the defined thresholds and/or geared to work independent of patient volume may further incentivize small hospital participation and success.”
- From *TIPFPRH*: “The development of a national P4P initiative should be coordinated with the work of the National Quality Coordination Board (as recommended by the IOM) to facilitate the standardization of the many data collection and reporting requirements of hospitals and providers (e.g., quality standards of other payers and possibly large employers as well as JCAHO, NQMC, NQF, HQA and others).”

RWHC Comments Re Data Collection and Validation

- We strongly support the statement on page 23 of the Issues Paper that lower volume hospitals have a “disadvantage” when the incentives do not “acknowledge that there are fixed costs for any hospital to measure and improve performance. A smaller volume hospital might achieve a high performance threshold and yet receive a relatively small incentive that is not commensurate with the resources dedicated to measuring and improving performance.”
- To the degree possible, individuals will respond better to rewards based on data in quarterly increments as well as “current data” versus “old data” (shorter lag times are generally believed to be stronger incentives for change).
- From *TIPFPRH*: “Future national P4P programs should include design features that accommodate varying degrees of information system sophistication to guide and encourage local markets with limited IT systems to build capacity through participation (e.g., include IT adoption as part of the P4P initiative and provide state or federal grants and/or low or no interest loans to speed adoption and implementation).”

RWHC Comments Re Incentive Structure

- See first bullet in the above section.
- Hospitals should be rewarded for showing improvement as well as having good rates to begin with.
- We agree strongly with the need to thoroughly think through unintended consequences of

payment incentives/disincentives designed for large urban hospitals but applied to much smaller hospitals serving rural communities (as implied by the question on page 23 of the Issues Paper). In particular this is where we need to listen very closely to the statistical challenges of small hospitals as well as shortcomings with even the best risk adjustment tools comes into play and worries us.

- From *TIPFPRH*: “Incentives should be provided to hospital and healthcare systems, networks, and alliances to foster greater sharing of resources and expertise toward a coordinated health information infrastructure capacity for small rural providers.”

RWHC Comments Re Public Reporting

The following recommendations are relevant to this discussion and are from the *Public Reporting of Hospital Quality in Rural Communities: an Initial Set of Key Issues* adopted by the National Rural Health Association Rural Health Policy Board on May 20th, 2005:

- “Consumers should be able, at a minimum, to readily compare all hospitals in their ‘hospital referral region,’ i.e. within the geographic service area in which the preponderance of patients are treated and referred.”
- “Hospital comparisons should be based on a core set of standard measures, even if lower volume hospitals must collect data for longer intervals to generate reliable results. Additional measures should be included to further describe the quality care in an array of more specific contexts, including but not limited to rural communities.”
- “Hospitals in rural communities should fully engage in the quality improvement and public reporting movement, actively preparing for a future when public reporting is a higher priority among payers and consumers.”
- “In all public reports, hospitals in rural communities should be presented in a manner that make it clear that they are “acute care hospitals,” defined by the Centers for Medicaid and Medicare Services on the Hospital Compare web site as ‘providing inpatient medical care and other related services for surgery, acute medical conditions or injuries.’ ”
- “Information about how Medicare categorizes a hospital for payment purposes should be available to the public but should not be the primary basis for organizing a public report on hospital quality.”
- “The appropriate comparisons are for the services rendered, not the size of institution.”
- “All relevant stakeholders should be actively involved in the complete development process of public reporting websites targeted at rural communities, from measure selection to report presentation. All public reporting websites should be pre-tested with a representative sample of consumers and hospitals located from affected communities.”
- “While all hospitals should have the opportunity to comment on the accuracy of the description of their organization and services before a website goes public, the primary

responsibility is with the web site owner to assure the accuracy of the information it offers. All sources of data and their known limitations must be cited. The site should have an on-line ability for site users to provide feedback.”

- “While the National Quality Forum recommends NOT publishing performance rates when the denominator is smaller than 30 (other sources cite 25), there is significant disagreement about whether or not to publish the raw data in such instances; more research and debate is needed.”
- “The visual presentation and graphics used on a website or in a report convey at least as much meaning as the text or data itself and must be as rigorously tested with the relevant audiences for unintended messages.”
- “The visual presentation, graphics and text accompanying a hospital with small numbers should always put the onus on the website, not the hospital, for the statistical challenges related to interpreting small numbers (e.g. ‘we have not yet collected enough information to reliably predict future performance’ rather than ‘be careful when drawing conclusions for these hospitals because of the small number of patients treated.’)”
- “When there is a statistical challenge related to interpreting small numbers, symbols such as red flags or warning symbols should be avoided; ‘neutral’ symbols should be selected so as to not suggest that there is a problem with the hospital.”
- “Public reports need to be careful to not imply from partial inpatient data what services are available in other inpatient areas as well as the outpatient and emergency room departments (e.g. a hospital may provide care to a significant number of heart attack patients in its emergency room that are transferred rather than admitted.)”
- “The national quality reporting movement must address the number of public reporting organizations and the continuing need for a common set of reporting formats and definitions.”

Please feel free to contact us if you think we may be helpful in sorting through the rural issues relevant to this initiative. Thanks.

Sincerely,

A handwritten signature in black ink that reads "Tim Size". The signature is written in a cursive, slightly slanted style.

Tim Size
Executive Director

cc: RWHC Hospitals