March 8, 2011

Donald M. Berwick, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1504-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Hospital Inpatient Value-Based Purchasing Program; Proposed Rule (CMS-3239-P)
January 13, 2011

Dear Dr. Berwick:

The Advanced Medical Technology Association (AdvaMed) welcomes the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Proposed Rule on Hospital Inpatient Value-Based Purchasing Program (HVBp). AdvaMed strongly supports moving to a system that rewards providers based on the quality of care delivered to Medicare beneficiaries. A well-designed HVBp program, if implemented properly, would be an important step in this direction. AdvaMed has concerns, however, that if not properly conceived and executed, a HVBp program could have detrimental consequences resulting potentially in unintended patient harm, limiting access to timely and proper care, as well as compromising future innovation.

AdvaMed member companies produce the medical devices, diagnostic products and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. AdvaMed’s members produce the majority of the health care technology purchased annually in the United States and a significant share purchased annually around the world. AdvaMed members range from the largest to the smallest medical technology innovators and companies.

AdvaMed has a longstanding interest and engagement in healthcare quality improvement issues. AdvaMed is a member of the National Quality Forum (NQF) and is an active
participant in the AQA Alliance, the AMA’s Physician Consortium for Performance Improvement (PCPI), and other coalitions and organizations seeking to improve health care quality.

AdvaMed understands the complexity of developing and implementing a HVBP program and applauds the agency for its goal of improving Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage high quality, more efficient professional services. We support the associated objectives of promoting the practice of evidence-based medicine, reducing fragmentation and duplication, encouraging timely coordination and effective management of patients with chronic diseases, accelerating use of health information technology, empowering consumers to make value-based health care choices, and encouraging health professionals to improve the value of care by disseminating transparent and useful information, if implemented properly. AdvaMed has the following comments regarding the development and implementation of a HVBP as put forth in the proposed rule.

I. General Comments

A. Value Assessment and Quality Outcomes

Quality in the hospital should be assessed by outcomes of care. Until better outcome measures are available, we understand the need to use process measures to assess quality. With the advent of new PPACA payment and delivery system reforms including Accountable Care Organizations, bundling of payments and other initiatives that will increase pressures to reduce the growth in health care spending, it is imperative that outcome measures be developed immediately to ensure patient access to appropriate and high quality care. We also recognize the importance of process measures in providing actionable items that providers may use to increase the quality of their care. Regardless of whether there are outcomes or process measures available for assessing quality of care, efficiency should be assessed only in relation to the care for which those outcomes and process measures exist.

Efficiency Measures Paired with Quality Measures--The proposed rule notes that for value-based incentive payments made with respect to discharges occurring during FY 2014 or a subsequent fiscal year, CMS is required by statute to ensure that the measures selected for the Hospital VBP program include efficiency measures, including measures of "Medicare spending per beneficiary." CMS is soliciting public comment as to what services should be included/excluded and what approaches should be used for measuring internal hospital efficiency. AdvaMed believes that measurement is the foundation of a value-based purchasing program. We believe that it is fundamentally important that measures of cost, or resource use, be considered only when accompanied by individual measures of quality related to the same health care. These measures should be used, rather than using more generalized measures such as the estimated cost per day.
Generalized measures may inappropriately mask the source of the savings and potentially impact detrimentally on quality.

**B. Episode of Care Must be Appropriate for Quality**

Accurate hospital quality and efficiency measures must be determined over an appropriate episode of care, which includes a period of time sufficiently long enough to capture all the value of the care. One could easily draw erroneous conclusions about the relative benefits and costs of care if an inappropriate time period is used. For example, a provider may have a choice between a lower-cost medical device which is expected to need replacement within a few years, necessitating another hospitalization, and a higher-cost device which will last many more years. If resource use, or costs, are measured based on an episode of care that only considers the hospitalization and perhaps a 90-day period post-discharge, the “total” cost of the episode would appear to be lower for care using the lower-cost device. This assessment would not count a possible readmission and replacement that would occur a few years later, which might make use of the higher-cost device more economical in the long run. Even a one-year period might be an insufficient to assess the benefits to patients of many new technologies. Considering episodes of care, resource use must be determined over an appropriate episode of care, which includes a period of time sufficiently long enough to capture all the benefits and value of the care. We believe that it only makes sense for efficiency — and measures dealing with efficiency — to be defined to include both quality and cost, and there should be no reduction in quality.

**C. Reducing Unintended Consequences**

AdvaMed strongly urges CMS to design the HVBP program to anticipate unintended consequences that may be associated with its implementation. AdvaMed strongly cautions CMS that one unintended consequence of a HVBP would be limiting patient access to innovative technologies (see full discussion below). The HVBP also should be designed to anticipate other potential consequences including discharging patients prematurely without appropriate follow-up, potentially limiting access to physicians, and other health care providers with appropriate education and medical/clinical expertise to treat specific conditions, and avoiding patients who are more ill or with numerous complications and co-morbidities. Accordingly, the criteria and rules for the HVBP program should be designed to prevent these unintended consequences from occurring.

**D. A HVBP Program Should Not Deter Implementation and Early Adoption of New Technology/Innovations**

AdvaMed urges CMS to consider the impact of a HVBP program on access to innovative products and services. The program should recognize that the lags in data used to measure quality and costs could have the effect of freezing current ways of practicing
medicine. Rapid updating of measures will help, but is not a complete solution to the problem. If early adopters of innovative treatments are penalized by being judged not to be in conformance with quality standards, because they use new treatments not reflected in the standards, the development and diffusion of new treatments and cures could be seriously compromised. Care must be taken in designing a HVBP program which is centered around quality measures so that effects are measured in appropriate windows (e.g., not just one or several months), otherwise the measures may not capture the full benefit of new cutting-edge devices and diagnostics, which will offer great strides in improving healthcare.

AdvaMed recommends that CMS develop adjustments that are necessary to recognize the use of new technology that leads to better quality or improved outcomes. Quality performance measures should include mechanisms to recognize and account for resources associated with and required by new technologies. The implementation of these measures should not deter physicians from being early adopters of new technologies. Moreover, certain therapies may also require follow-up care protocols to ensure the optimal treatment and health outcomes. AdvaMed believes that a HVBP program, if implemented properly, should reward providers for attaining the highest quality of care. We do not support a program that rewards providers for delivering lower quality, even if provided at lower cost.

To encourage innovation AdvaMed recommends that CMS establish in the HVBP program a time limited carve out of patients undergoing innovative treatment from a measure, thereby excluding that patient from the measure’s numerator and denominator when assessing a provider’s performance on the measure. It is also imperative that measures be modified when appropriate in order to encourage innovation in healthcare.

AdvaMed further recommends that any measure of the cost or resource use for a service should adequately reflect the costs of any new technologies involved in the service. One approach for doing this would be to modify Medicare’s existing new-technology add-on payments for MS-DRGs. Important modifications to the existing policy applying to the inpatient hospital setting include:

1) Lowering the current cost threshold required to trigger the add-on payment, to allow more new technologies to qualify for consideration.
2) Increasing the amount of the add-on payment recognized for purposes of reimbursement.
3) Allowing major incremental improvements in technologies (e.g., a battery that lasts 10 years rather than 5) to meet the test that the technology is new.
4) Allowing a broader range of evidence to be considered in assessing whether a new technology meets the test of providing substantial clinical improvement over an older technology.
5) Providing flexibility to the test that a new technology meets the substantial clinical improvement test by allowing new technologies to meet this test by demonstrating that there is substantial likelihood that clinical improvement will result. This flexibility is necessary to ensure that those products and services that may not have conclusive evidence in the short period of time, for which an add-on payment would be available, are accessible to Medicare beneficiaries.

E. Outcomes Measures/Risk Adjustment

In the proposed rule, CMS states that it intends to add outcomes measures to the Hospital VBP program in FY2014, but did not specify how these outcomes domains will be weighted. The proposed outcomes measures -- mortality measures, hospital acquired condition (HAC) measures, and AHRQ patient safety measures -- are greatly dependent on adequate risk adjustment as well as accurate reporting.

AdvaMed wishes to emphasize the importance of considering risk factors in the development and implementation of a HVBP program particularly with respect to outcome measures. Risk adjustment is a key element that must be valid, reproducible, sensitive and specific. Any flaws that may be present in the methodology to examine risk adjustment can potentially lead to flawed conclusions and therefore compromise the validity of the resultant conclusions.

Currently, there are numerous weaknesses associated with risk adjustment methods for the proposed outcomes measures. For example, the mortality measures do not exclude patients receiving palliative care treatment only in the hospital, which can alter the mortality measure results for some hospitals and may incorrectly penalize hospitals offering substantial palliative care programs.

Over time, it is likely that there will be marked improvement of the risk adjustment and reporting methods. Therefore, AdvaMed supports implementing a phased-in approach to the weighting of measure domains such that, over time, the outcome measures make up a higher percentage of the total and the process of care measures/Patient Experience measures make up a lower percentage of the total overall.

F. Sub-regulatory Process

CMS is proposing to use a subregulatory process to expedite the timeline for addition of new measures to the VBP program by allowing the agency to add measures to the HVBP program beginning with the FY2013 program. Under this proposal, CMS could add (and retire) any measures to the HVBP program if they have been adopted in the hospital IQR pay-for-reporting program and published on the Hospital Compare website for at least one year.

AdvaMed understands CMS’s desire to hasten the addition of new measures to the HVBP program in the future. However, AdvaMed strongly believes that all measures chosen
for the HVBP program should have NQF approval, and secondly, should be properly vetted for public input using the notice and comment rulemaking process.

AdvaMed believes that all stakeholders should have the occasion to comment on whether such measures are appropriate to include in the HVBP program. AdvaMed strongly feels that this feedback is critical to the success of the Hospital VBP program.

II. Specific Comments

A. Proposed Selected Measures

1. Proposed FY 2013 Measures
For FY 2013, CMS proposes to include 17 clinical process measures, and results of the HCAHPS survey. The proposed clinical process measures include: acute myocardial infarction (three measures), heart failure care (three measures), pneumonia care (four measures), surgical care, healthcare-associated infections/Surgical Care Improvement Project – SCIP (four measures) and surgical care – SCIP (three measures).

a) Topped-Out Measures
In selecting measures for the HVBP program from among the candidate measures reported under the IQR, CMS proposes to exclude measures that are “topped out”, those for which all but a few hospitals have achieved a high level of performance. CMS identified these as measures for which the scores at the 75th and 90th percentiles are indistinguishable, and for which the scores are tightly clustered around the mean (as measured by a truncated coefficient of variation that is less than 0.10.)

AdvaMed supports the proposed exclusion of topped out measures. The HVBP program should encourage hospitals to achieve quality improvement, and this aim will not be achieved if the program is built on measures for which hospital performance is already universally high. We note that hospital groups have commented that analyses of variation in hospital performance on measures using the most recent Hospital Compare data indicate that several of the measures proposed for 2013 appear to be nearly topped out, particularly those for Aspirin at discharge (AMI-2), evaluation of LV function (HF-2), and antibiotic selection for surgical patients (SCIP-Inf-2). The final rule should ensure that the measure set maximizes the promotion of quality improvement.

b) Use of Administrative Claims Data
AdvaMed has strong concerns regarding the use of administrative claims-based data for developing quality performance measures, especially those involving hospital HAIs. Although administrative data is used in quality performance measures, it is important to emphasize the need for complete data on patient encounters with the health care system.
It is important to note that claims data lack robust clinical information and other pertinent patient data, such as those contained in medical records and therefore, provide only an incomplete picture of the relevant clinical information. For example, accurately capturing data on the rate of surgical site infections is likely to be unachievable without some medical record abstraction.\textsuperscript{1} It is not possible to calculate a surgical site infection rate without rigorous validation of antibiotic dispensing data with the medical record in order to confirm that medications were prescribed for surgical site infections, rather than as part of routine post-operative prescribing practices. Therefore, meaningful infection rates are very difficult or impossible to derive from administrative data sources alone. Although administrative data can be easily obtained and analyzed, the usefulness of these data to hospital infection control professionals and state reporting programs has been limited in the past by the poor positive predictive value for identifying cases of HAI.\textsuperscript{2,3,4} Therefore, its proposed use for routine HAI control surveillance, HAI public reporting, inter-facility comparisons and non-payment for performance has been seriously questioned.

c) Healthcare-Associated Infection ("HAI") Measures

AdvaMed commends CMS for selecting measures for FY 2013 that have all previously been endorsed by the National Quality Forum (NQF). However, we recommend that CMS consider selection of additional clinically meaningful measures for the HVBP program.

AdvaMed strongly believes that among the measures that CMS is considering for implementation in a HVBP, those related to the prevention and control of healthcare-associated infections (HAIs) should be a significant priority to prevent hospital services from resulting in avoidable harm. The importance of controlling HAIs has been highlighted in several recent reports. In 2010, a report by Milliman notes that postoperative infections are the second most common and costly medical errors that occur.\textsuperscript{5} A recent report by the Philadelphia Health Care Cost Containment Council

\textsuperscript{1} Scinto, JD et al., *Use of Administrative Data in Measuring Quality of Care*. Qualidigm (Prepared for the Rhode Island Department of Health (HEALTH) Aug. 2000.

\textsuperscript{2} Sherman, ER et al., *Administrative Data Fail to Accurately Identify Cases of Healthcare-Associated Infection*. Infect Control Hosp Epidemiol 2006; 27:332-337.

\textsuperscript{3} Wright, SB et al., *Administrative Databases Provide Inaccurate Data for Surveillance of Long Term Central Venous Catheter-Associated Infections*. Infect Control Hosp Epidemiol 2003; 24:946-949.

\textsuperscript{4} Stevenson, KB et al., *Administrative Coding Data, Compared with CDC/NHSN Criteria, are Poor Indicators of Health Care-Associated Infections*. Am J Infect Control 2008; 36:155-64.

\textsuperscript{5} Shreve J, et al., *The Economic Measurement of Medical Errors* (Sponsored by the Society of Actuaries' Health Section). Milliman June 2010
reviewing hospital infections in Pennsylvania hospitals in 2007 reveals the following statistics: (1) the mortality rate for patients with a hospital-acquired infection was 12.2%, while the mortality rate for patients without a hospital-acquired infection was 2.0%; (2) the mean length of stay for patients with a hospital-acquired infection was 19.7 days, while the mean length of stay for patients without a hospital-acquired infection was 4.4 days; (3) the median length of stay for patients with a hospital-acquired infection was 15.0 days, while the median length of stay for patients without a hospital-acquired infection was 3.0 days; (4) the mean total hospital charge for patients with a hospital-acquired infection was $191,872, while the mean for those patients without such infections was $35,168; and (5) The median total hospital charge for patients with a hospital-acquired infection was $87,655, while the median for those patients without such infections was $19,748. These striking statistics reinforce the need to actively control HAIs head-on through a well-implemented program.

The provisions in the ACA specify that the VBP program will include measures concerning healthcare-associated infections. For FY 2013, CMS has chosen four Surgical Care Improvement Project (SCIP) measures to satisfy this requirement. AdvaMed believes that the particular selection of SCIP measures may not fully address this important area of patient safety. The Surgical Care Improvement Project (SCIP) was established in 2006 and the objective was to reduce surgical complications by 25% in 2010. These SCIP measures have, however, a peripheral impact – as opposed to a direct impact – on controlling HAIs.

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This report listed the 10 most expensive types of errors in 2008, the number of errors, the cost per error, and the total cost. The first five make up 55% of the total error costs.

The list is as follows:
1. Pressure ulcers—374,964 errors, $10,288 per error and $3.858 billion total.
2. Postoperative infections—252,695 errors, $14,548 per error, $3.676 billion total.
3. Mechanical complication of a device, implant or graft—60,380 errors, $18,771 per error, $1.133 billion total.
4. Post laminectomy syndrome—113,823 errors, $9,863 per error, $1.123 billion total.
5. Hemorrhage complicating a procedure—78,216 errors, $12,272 per error, $960 million total.
6. Infection following infusion, injection, transfusion, vaccination—8,855 errors, $78,083 per error, $691 million total.
7. Pneumothorax—25,559 errors, $24,132 per error, $617 million total.
8. Infection due to central venous catheter—7,062 errors, $83,365 per error, $589 million total.
9. Other complications of internal (biological) (synthetic) prosthetic device, implant and graft—26,783 errors, $17,233 per error and $462 million total.
10. Ventral hernia without mention of obstruction or gangrene—53,810 errors, $8,178 per error and $440 million total.

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Several studies, including a recent one by Stulberg et al., however, indicate that adherence on individual SCIP measures did not significantly lower the probability of postoperative infection. This study was based on data obtained on 405,720 discharges from 398 hospitals in which SCIP performance was recorded. The authors noted that “Based on our findings, the individual item performance rates reported publicly do not fulfill their stated purpose of pointing consumers toward high-quality hospitals.” AdvaMed believes that instead, addition of the HHS HAI metrics to the HVBP program would improve the program. These metrics comprised of nine national targets for elimination of healthcare-associated infections including central-line associated bloodstream infections (CLABSI), adherence to central-line insertion practices (CLIP), Clostridium difficile hospitalizations and infections, urinary tract infections, MRSA infections, Surgical Site Infections (SSI) and SCIP measures. Addition of these metrics to the proposed HVBP program would provide a robust set of measures aimed at significantly decreasing the number of hospital healthcare-associated infections in the future. AdvaMed recommends that CMS adopt this more comprehensive set of measures rather than just the four SCIP measures alone.

AdvaMed believes that both central-line associated bloodstream infections (CLABSI) and Surgical Site Infections (SSI) measures should be added to the proposed HVBP program, as soon as feasible and contingent on their approval by NQF. Both CLABSI and SSI have been chosen as measures required to be reported under the CMS Hospital Inpatient Quality Reporting Program (formerly known as the RHQDA program).

CLABSI are deadly but highly preventable HAIs, with a reported mortality rate of 12%-25%. Major reductions have occurred in the burden of CLABSI in ICUs. A recent CDC MMWR report notes that in 2009 alone, an estimated 25,000 fewer CLABSI occurred in U.S. ICUs than in 2001; a 58% reduction. This represents up to 6,000 lives saved and $414 million in potential excess health-care costs avoided in 2009 and approximately $1.8 billion in cumulative excess health-care costs saved since 2001. While these results indicate progress in ICUs, significant numbers of CLABSI still occur in other parts and departments in the hospital and in other institutional care settings. The report states that “continued success in CLABSI prevention will require increased adherence to current CLABSI prevention recommendations, development and implementation of additional

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7 Stulberg, JJ et al., Adherence to Surgical Care Improvement Project Measures and the Association With Postoperative Infections. JAMA 2010: 303(24): 2479-2485

8 For CLABSI, data collection begins with January 1, 2011 discharges, and will be reported by NHSN to CMS for FY 2013 Medicare payment determination. For SSIs, data collection will begin with January 2, 2012 discharges, and will be reported by NHSN to CMS for FY 2014 Medicare payment determination.

prevention strategies, and the ongoing collection and analysis of data, including specific microbiologic information.”

Surgical Site Infection (SSI) measures should also be added to the HVBP program, as numerous studies show that these infections can be prevented. For example, Pfoahl et al., recently performed a study looking at all admissions to an 800-bed tertiary care hospital and the relationship to eradication of the carrier state in MRSA-screened patients using 2 percent mupirocin nasal ointment and 4 percent chlorhexidine soap before surgery. Since the initiation of the universal MRSA screening, only 11 patients out of 8980 (0.12%) undergoing SCIP procedures developed MRSA.

Use of CLABSI and SSI measures may present a fundamental pathway for hospitals to decrease and control infection rates and lower morbidity and mortality risks associated with HAIs. Addition of these measures to the HVBP program would strongly bolster the HAI prevention portion of the program.

AdvaMed also supports informing the public about each hospital’s performance regarding infection control. AdvaMed wishes to emphasize the need for transparency in the processes that evolve around the quality HAI-related measures chosen and any guidelines developed for implementation in the hospital setting.

AdvaMed also recommends that CMS consider, to the extent possible, encouraging the adoption of IT solutions, especially in the field of infection prevention, in order to capture more accurate and patient-reflected data than currently available using administrative data. Furthermore, AdvaMed urges CMS to adopt measures that support hospitals being more accountable for implementing HAI prevention methods that focus on using all available resources that can positively impact on provider behavior and processes, as well as applying existing antimicrobial technologies that can provide another defensive line against infection risks where there may be lapses or breakdowns in processes and human behavior.

**d) HCAHPS Measures**

For FY 2013, CMS proposes that the HCAHPS domain would account for 30 percent of the hospital’s score, with the remainder 70% attributable to the clinical process measure domain. Although AdvaMed understands the value of surveying patients regarding their health care experiences and believes it is an important tool in improving patient-centered care, we have concerns placing too much weighted emphasis on the HCAHPS survey tool in the HVBP program. Various studies have shown that HCAHPS scores can be

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significantly impacted by diverse patient characteristics and thus introduce bias into the process. For example, Elliott et al., found that hospital "ranks" (the relative scores of hospitals for patients of a given type) can vary substantially by patient health status and race/ethnicity/language, and moderately by patient education and age.11 This reporting disparity is likely to be very evident among those with life-threatening illnesses and those with symptoms such as depression, thus reflecting a potentially lower HCAHPS score, without being adjusted for these differences.

Although these questions/surveys reflect a part of overall quality in the health care experience, they — and other patient engagement mechanisms — do not assess clinical differences, which are integral to health care quality measurements. AdvaMed also strongly cautions that as a result of using patient engagement or patient experience data in quality measures, there is an extremely high potential for patients relying upon misrepresentative data. AdvaMed would like CMS to carefully consider ways to mitigate the potential bias effects as they implement patient experience of care, HCAHPS measures and potential improvements necessary to the HCAHPS survey tools as it considers the weighting domains in the new HVBP program.

2. Proposed FY 2014 Measures

For the FY 2014 Hospital VBP program, CMS proposes adding the 30-day mortality claims-based measures AMI, heart failure and pneumonia mortality measures. Additionally, CMS proposes adding nine AHRQ Patient Safety Indicator and Inpatient Quality Indicators and eight Hospital-Acquired Conditions (HACs) measures. All of these measures are currently included in the HIQR program for the FY 2013 payment determination.

a) AHRQ Measures

AdvaMed understands that many of the AHRQ indicator measures have limited sensitivity and specificity, which is critical for use in any VBP program.12,13 These indicators are derived from administrative databases/algorithms, and as noted above, they are much more limited in terms of the clinical information made available than measures derived from clinical chart abstraction. AdvaMed also understands that some of the AHRQ indicators may be associated with a high false positive rate, indicating potential problems in the process. AdvaMed strongly believes and urges CMS to not use any


measures that rely on flawed data for any value-based purchasing program or public reporting.

AdvaMed suggests that CMS consider delaying adding these measures to the HVBP program for FY 2014 pending additional testing for suitability in the program. Additionally, AdvaMed suggests using the risk adjustment methods available -- based on DRGs, demographics, and comorbidity categories -- with the AHRQ patient safety indicators when they are added in FY2014.

**b) HAC Measures**

AdvaMed strongly recommends adding risk adjustment to the hospital acquired condition (HAC) measures from the hospital IQR program before adding them to the hospital VBP program in 2014. For the FY 2014 HVBP program, the proposed HAC measures are those adopted for the hospital IQR program in the FY 2011 inpatient PPS final rule, which are not risk-adjusted. The ACA requires that CMS provide risk-adjustment for the HAC measures used to adjust hospital payment under Section 3008. As noted above, risk adjustment is crucial in order to account for the differences in patient populations among hospitals. AdvaMed requests that CMS explain how it will reconcile this issue—either by revising the measures at a later date to achieve compliance, or by reporting a separate version of HAC measures, one for the VBP program and the other with regards to section 3008.

In addition, as noted above, AdvaMed suggests that the Centers for Disease Control and Prevention’s (CDC) measures which assess central line-associated bloodstream infections (CLABSI) and surgical site infections (SSI) are more suitable outcomes measures for future additions in the HVBP program. Hospitals have been submitting information on CLABSI rates through the CDC’s National Healthcare Surveillance Network (NHSN) for the Medicare hospital inpatient quality reporting program, since January 2011. Likewise, hospitals will begin reporting on SSI rates in January 2012. These CDC measures are derived from clinical data and well-respected in the medical and scientific community. Importantly, the CDC measures have been endorsed by the NQF.

**B. Validation**

CMS is proposing that the FY 2013 HVBP program use the same validation process that was adopted for the FY 2013 HIQR program in the FY 2011 IPPS final rule (75 FR 50227 through 50229). AdvaMed agrees with this approach -- pay for reporting and HVBP programs to coincide with the same validation process -- which avoids placing an additional burden on hospitals to separately return requested medical records for the HVBP program.

**C. Feedback/Performance Period**

AdvaMed understands the limitations in instituting the HVBP program for fiscal year 2013 payment, however, AdvaMed strongly urges CMS to adhere to a minimum of a
12-month baseline and performance period for all future measures included in the HVB program. AdvaMed believes that this should be an adequate hospital performance period before determining any performance scoring and payments calculation that result from these performances. The importance of this performance period cannot be overemphasized to ensure that there are replicable measures and standards that can be easily reproduced throughout the country at most acute care facilities. This will allow valuable feedback to be provided to CMS on a variety of hospitals in various settings and the ability to apply the same measures and report on the same standards.

D. Transparency

CMS proposes to publish hospital scores regarding each measure, the domain-specific score, and the total performance score on the Hospital Compare website. CMS also proposes to periodically post aggregate information on payments under the hospital VBP program to the Hospital Compare website. AdvaMed supports CMS’s approach towards transparency and public presentation of results.

AdvaMed recommends that CMS publish the HVB payment adjustment percentages by hospital – in addition to the hospital scores – on the Hospital Compare website. The payment adjustments will be integrated into the claims processing system and thus captured in Medicare claims data used for analytic and reporting purposes, however, we believe that it is important to publish the payment adjustments alongside the quality measure results. AdvaMed also suggests that CMS make hospital-specific adjustments and bonuses under the Hospital VBP program available in easily accessible public use data files.

AdvaMed welcomes the opportunity to present these comments on the development and implementation of a hospital value-based purchasing program. We would be pleased to answer any questions regarding these comments. Please contact me at (202) 434-7207 or sbrotman@advamed.org if we can be of further assistance.

Sincerely,

[Signature]

Steven J. Brotman, M.D, J.D