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Centers for Medicare and Medicaid Services
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The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the U.S. Department of Health and Human Services (HHS) Medicare Hospital Value-Based Purchasing (VBP) Options Paper.

AHIMA is a not-for-profit professional association representing more than 51,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by collecting, managing, analyzing, reporting, and utilizing data which is vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most.

AHIMA and its members participate in a variety of projects with other industry groups and Federal agencies related to the use of healthcare data for a variety of purposes including direct care, quality measurement, reimbursement, public health, patient safety, biosurveillance, and research.

AHIMA commends the Centers for Medicare & Medicaid Services (CMS) for carefully gathering and assessing input from industry stakeholders during the development of the VBP Options Paper. The Options Paper is well documented and easy to understand. We believe the Options Paper provides a good foundation; however, we have outlined some recommendations for consideration as CMS continues to refine the VBP Program. Our comments focus on those areas of particular interest to our members.

VBP Plan Goals, Assumptions, and Design Considerations
AHIMA recognizes the industry and public needs for timely and accurate data depicting the quality and safety of America's healthcare system, but manual data abstraction is not a viable long term option for any healthcare organization, especially as quality measurement and other secondary data requirements continue to increase both nationally and locally. In addition, extracting data electronically from interfaced systems remains a challenging process because there are few broadly agreed-upon standards for data content.

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Uniform data content standards are crucial in the effort to achieve VBP. These standards will facilitate a process for automated data transmission, and electronic health record (EHR) vendors will be more apt to integrate measurement reporting capabilities into EHR products if measure specifications are standardized across the industry. This will streamline hospital data submission procedures and offer the ability for providers to view real-time measurement results to initiate their own improvement interventions in a more timely and efficient manner.

Hospitals that are currently collecting this data for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program are struggling to keep up with the new measures and changes being introduced by the Joint Commission, CMS, and health plans and payers. While the intent of the VBP is important, it is critical to understand; as long as the emphasis on the measures used relies on manual data collection, at some point it will sink under the weight of this burden.

It is unfortunate that HHS chose not to move forward with the 2003 National Committee on Vital and Health Statistics recommendation that HHS adopt the ICD-9-CM upgrades (that is ICD-10-CM and ICD-10-PCS). Had ICD-10-CM and ICD-10-PCS been moved through the adoption process, more detailed data would now be available and would significantly add to the knowledge needed to judge severity, quality, and other factors under consideration.

AHIMA remains concerned that even though there is an active program under way to develop standard measurements for quality, the lack of detailed diagnosis and procedure data that could be available with the use of ICD-10-CM and ICD-10-PCS will make the information gathered incomplete and inconsistent when it comes to measuring quality and other factors. The VBP relies heavily on data and its ability to judge the quality of a facility's measurement based upon the quality of the data, therefore the lack of detailed codes that ICD-9 offers will cause a conflict between CMS quality definitions and those of an eminent and more robust coding system.

Performance Assessment Model

Setting Benchmarks and Attainment Thresholds

CMS states that the list of required measures will continue to be expanded and hospitals will be required report on all measures, including those that are topped out. AHIMA understands the need for continuing to incentivize the subset of hospitals that have not yet achieved a high level of performance, but we request that CMS consider developing criteria for phasing out topped out measures over time. This will allow for allocation of resources to measurement efforts that require more widespread improvement.

Translation of VBP Performance Score into Incentive Payment

The general concept of the incentive payment seems clear and including both the benchmark performance as well as exchange rate seems to provide hospitals with the ability to achieve

some portion of the incentive payment by showing improvement year after year even if an overall benchmark status is not achieved. AHIMA recommends that CMS provide additional explanation for how the performance levels will be established each year to facilitate transparency and provide an overall understanding of how the targets will be defined. This is especially important for hospital planning and budgeting purposes when trying to achieve, at a minimum, the attainment level.

Options Regarding Structuring Incentive Payments

Basis of Incentive Payments

All components of the Inpatient Prospective Payment System (IPPS) are factored into the resources that are utilized when treating patients as well as addressing the data requirements for quality measure reporting. AHIMA recommends that CMS consider basing the incentive on all components of the IPPS payment to include and recoup the necessary resources.

Allocation of Residual VBP Incentive Payments

If the goal of the VBP Plan is to encourage hospitals to continually improve over time, then AHIMA recommends Option #1: Distribution to all hospitals based on their VBP performance scores. This option will reward hospitals that achieved any type of incentive payment, rather than focus on the top performers thereby increasing the disparity as Option #2 would promote.

VBP Measures

AHIMA agrees with CMS' criteria for evaluating VBP measures, but must stress the importance of assessing the feasibility of the data collection and reporting process for quality measures. As CMS continues to increase the number of required measures for VBP, the feasibility of collecting high quality data in an efficient and effective manner, in today's paper/electronic environment, should be a top priority.

Additional Measures for Fiscal Year 2010 and Beyond

On page 26 of the Options Paper, it indicates that CMS anticipates retiring some measures from VBP for a variety of reasons, including changes in science or policies. The document then states, "CMS may determine that a measure no longer warrants a financial incentive even though the measure continues to have value for public reporting. In this case, hospitals still would be required to report data on the measure in order to be eligible for the VBP financial incentive." AHIMA recommends that CMS further clarify the rationale and criteria for assessing measures for VBP financial incentive versus those measures that could be required strictly for public reporting. In addition, the paragraph is confusing as there does not appear to be a differentiating factor among those measures that are retired due to changes in science and are no longer effective versus those measures that are continued for the purpose of public reporting. AHIMA recommends that CMS separate the two different but associated concepts and explore their value added to the health care system.

CMS indicates that the introduction of new measures will involve a process of development, testing, and preliminary data submission. AHIMA recommends that CMS provide additional information regarding these processes, including timeframes and opportunities for hospital and professional participation and feedback.

Small Numbers on Individual Performance Measures

Although the incentive payment system has been articulated on a high level, there are missing details on how this program will integrate small and/or rural facilities that may not have enough cases to report on the measures. AHIMA recommends the consideration of utilizing potentially different incentive scales for different sizes of hospitals to allow smaller facilities an opportunity for continued engagement in the program without continued exemption from potential incentive payments due to their size and structure.

Transitioning from RHQDAPU to VBP

Due to the size and nature of the VBP Plan that CMS will be implementing, AHIMA strongly recommends the selection of Option #1, a phased approach. Program changes of this size require a significant amount of planning for resources and budgeting, therefore presenting the plan with defined periods of adjustment will allow the health industry – providers, payers, vendors, and hospitals – to ensure a more smooth transition through the phased approach. Additionally, with many regulatory changes occurring over the next year that will affect the IPPS payment structure, hospitals are struggling to get a handle on the analysis of cost-based payments as well as the change to a severity based DRG system. Phasing in this incentive program will allow hospitals to be better prepared for the change.

Redesign of the Data Infrastructure to Support VBP Program

Compress the Data Submission Period

While timely data is an important goal, both the decrease in submission period and move toward monthly reporting will increase the data collection and submission burden for both hospitals and vendors. Manual data abstraction can be quite burdensome and shorter submission time periods may compromise the data abstraction process resulting in insufficient and incomplete data and possibly inaccurate performance measurements.

Allow Data Resubmissions

Providing the ability to resubmit data has long been requested by both hospitals and vendors. This is especially important when there may be systematic errors in understanding a data definition or that might bias a hospital's results if not corrected. The introduction of new measures and the continual change in measure specifications over the years has increased the need for the ability to correct data. AHIMA supports the proposal to allow data resubmissions not currently supported under the RHQDAPU program.

Improve Data Submission Feedback Reports

AHIMA supports the goal of improving the data submission feedback reports and looks forward to learning more about what the reports will look like as well as what information will be addressed within these reports. We recommend that CMS not only provide the feedback reports to hospitals, but to hospitals' vendors upon request, to ensure prompt response and improved communication among the organizations involved.

Strengthening the Ability to Compute Stable Performance Rates: Sampling Methodology

AHIMA recommends that CMS provide more specific information regarding the criteria that will be used for increasing the minimum sample sizes. In addition, CMS should further explain the process for submitting the population and sample counts to assess compliance with sampling methodologies (for example, frequency and method for submission, content of the submission, and so on). AHIMA recommends that CMS provide sufficient detail to understand the process and drivers for random sampling of cases. Without presenting specific guidelines and direction on the requirements for sampling, it will pose a challenge for those health information professionals who are required to pull or extract cases for submission.

CMS indicates a recommendation for increasing the minimum required sample size for each measure under the VBP program. AHIMA cautions CMS in increasing the sample size as this has a direct impact in the data collection burden for the hospital. Many hospitals collect the data through manual processes, therefore this increase in sample size may also increase the administrative burden required to comply with this directive.

AHIMA understands that the penalty for failing validation is suppression of data from Hospital Compare for the following 12 months; however, CMS does not provide detailed information regarding the issues surrounding potential fraudulent reporting. AHIMA recommends that CMS provide more information regarding the detection process and how there is differentiation between truly fraudulent submissions (i.e., "cherry picking") and those hospitals that have made honest errors in their submission. If a sincere mistake has occurred and a hospital is penalized, explain how the issues can be resolved.

Strengthening Data Validation

As long as hospital medical records continue to reside in a paper-based format, or electronic formations that are inconsistent and don't allow for the necessary data capture and architecture to permit uniform and automated reporting, the validation process will remain labor intensive. In the interim between now and when a substantial number of hospitals have implemented EHRs, the data submission and validation process proposed by CMS is an improvement over the existing process, but we request that CMS consider a process for accepting electronic copies of medical records from those hospitals that are leading the way in EHR adoption.

In addition, CMS proposes a revised methodology to strengthen the validation to assess the accuracy of measure rates. Outlined in this methodology is increased review for those hospitals that show inconsistent data patterns or an abnormally high rate of exclusions. In the same respect, AHIMA recommends decreasing validation reviews for those hospitals that continually demonstrate consistent patterns and positive measure reporting.

Creating a Single Hospital Quality Data Repository and Data Infrastructure

Existing data submission and validation processes within the RHQDAPU program could be streamlined if data could be exported in an automated and standardized manner from hospital EHR systems – this in turn would be an incentive for facilities to adopt the EHR. CMS must also keep in mind and play a role in the development of a nationwide health information network (NHIN). It would be inappropriate to have a mechanism developed unilaterally for Medicare that could conceivably be incorporated into the NHIN at the same time as similar measures for other health plans creating duplicate but disparate systems. Similarly, CMS' QIO contractors should be involved in the local efforts underway in many communities for health information exchange to assure consistency and uniformity, as encouraged by HHS.

Data collection and aggregation is a large undertaking that requires a significant amount of resources and administrative burden to address. The health care industry cannot continue to subsidize unfunded mandates of unaligned systems. There is an urgent need for the coordination and consensus in the development of standard measures that aide in the reduction of costs and misalignment of measures. More succinctly – the US health care system needs infrastructure to support measurement requirements before a consistent quality product can be produced. Our members report serious problems with different health plans' measurement processes that result in conflicting reports regarding the same provider. This alarms providers and confuses consumers.

Public Reporting

Consumer education and awareness of this program is critical to understanding these very complex issues and programs that CMS will be implementing. Information presented on the CMS website should target served populations and provide easy to understand messages and information regarding its meaning. In addition to Medicare consumer education regarding quality comparisons, we also suggest that CMS take part in educating citizens of the importance of collecting secondary data for quality measurement and other key uses. As organizations build systems to report quality data, many citizens are becoming alarmed with the release of such information.

AHIMA has launched a very successful personal health records (PHR) campaign and has developed a very comprehensive program for ensuring education and awareness for the public. AHIMA recommends that CMS visit the www.myPHR.com to learn about a potential model for implementing a large consumer education campaign.

Data Displays
AHIMA agrees with need to modify data displays for consumers. CMS should consider establishing focus groups and other forums with consumers and subject matter experts (SME) to develop and implement and effective and useful tool for consumers.

General Comments
As stated above, AHIMA supports uniform adoption of uniform data content standards and believes it will significantly improve clinical care and provide good secondary data for a variety of purposes including quality measurement. AHIMA's 51,000 HIM professionals are active developers and promoters of standards for the EHR and want to see a day when secondary data, whether it is being produced for quality measurement, public health reporting, or reimbursement, accurately portrays the diagnoses, severity, and services or procedures provided.

If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please contact Crystal Kallem, RHIT, AHIMA's director of practice leadership at (312) 233-1537 or crystal.kallem@ahima.org, or me at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

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cc: Crystal Kallem, RHIT
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