THE HEALTHCARE QUALITY COALITION

June 16, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS– 1632–P
P.O. Box 8013
Baltimore, MD 21244–1850

Re: Comments on Proposed Rule CMS-1632-P: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals

Dear Acting Administrator Slavitt:

On behalf of the Healthcare Quality Coalition (HQC) we are writing to respond to the request for comments relating to the Hospital Readmissions Reduction (HRR), Hospital-Acquired Conditions (HAC), and the Hospital Value-Based Purchasing (VBP) programs described in the Hospital Inpatient Prospective Payment System (IPPS) proposed rule for FY 2016.

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. Our provider systems have more than 19,000 licensed hospital beds, more than 21,000 physicians, and 225,000 employees across the country. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment systems that reward value and are pleased to provide comments on the future policies impacting the Hospital HAC, HRR, and VBP programs.

F. Hospital Value-Based Purchasing (VBP) Program

The HQC supports the goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement. Overall, the HQC believes the program is moving in a positive direction by emphasizing outcome measures, proposing to remove process measures and maintaining the weighting of efficiency and cost reduction metrics. We also support CMS' efforts to align the hospital VBP program with existing hospital and physician quality reporting initiatives, as well as the physician value-based payment modifier.

However, we continue to believe that the current statutory structure of the program makes it ineffective in driving meaningful reform. The incentive amounts are small, and the payment differentiation among most hospitals is the program has been small. The HQC recognizes CMS lacks the authority to remove the 2% cap on payment incentive amounts, but we want to be clear incentives at this level will not sufficiently motivate hospitals to strive toward value-based care delivery.

Hospital VBP Performance Scoring Methodology

- **CMS should incrementally phase out improvement scoring for select measures that have been included for several consecutive years to emphasize comparative achievement performance.**

The hospital VBP program was designed to both encourage improvement and reward achievement. Recognizing improvement at the outset of the program is very important to encouraging hospitals to invest in quality improvement, and the HQC continues to support the inclusion of improvement incentives in the VBP program. However, for measures included in the program for a number of performance years, the HQC believes that improvement scoring on select measures should be phased out over time such that hospitals are compared and paid on their achievements, while still having the opportunity to improve in newly implemented measures. The HQC recommends CMS consider developing a plan for incrementally phasing out improvement scoring for select measures that have been included for several consecutive years to emphasize comparative achievement performance.

Hospital VBP Program Measures

- **The HQC supports an increased emphasis on outcome-based measures, and removal of measures "topped out," and/or losing NQF endorsement.**
- **We support the removal of proposed process measures in the proposed rule, and suggest CMS flag any additional measures *approaching* "topped out" status in future rulemaking.**
- **The HQC also supports the proposed inclusion of 3-Item Care Transition Measure for the FY 2018 program year.**
- **Although we appreciate the focus on developing additional outcome measures and support alignment with other initiatives, inclusion of infection measures are already part of the Hospital Acquired Conditions Reduction program, resulting in overlap .**

Removal of Program Measures

Overall, the HQC supports the strategic goals of the National Quality Strategy and CMS in transitioning the program towards emphasizing outcome-based measures. Thus, we continue to support the removal of process measures deemed "topped out" where little difference in performance exists among high and low performers. This approach ensures that hospitals are not adversely affected by an insignificant difference in actual performance. Additionally, the HQC continues to support the removal of measures losing endorsement by the NQF.

In the FY 2018 program year, CMS proposes to remove two process measures from inclusion in the program: IMM2-Influenza immunization and AMI 7-Fibrinolytic agent received within 30 minutes of hospital arrival. Because the clinical process of care domain would only have a single measure, the proposed rule removes the domain completely. The HQC supports removing these "topped out" measures for the FY 2018 program year and also supports complete removal of the clinical process of care domain in FY 2018.

New Measures of Quality and Patient Experience

For the FY 2017 program year, the FY 2015 rule finalized the inclusion of two measures for inclusion in the Patient Safety domain: Clostridium difficile infection and Methicillin-Resistant *Staphylococcus aureas* Bacteremia. Infection-related measures are already part of the Hospital Acquired Conditions reduction program, and although we support alignment between different programs, overlapping of measures may unnecessarily reward or penalize hospitals the same in separate programs.

In addition, the FY 2016 proposed rule includes the 3-Item Care Transition Measure (CTM-3) for inclusion in FY 2018. This measure set includes the following patient-reported data: Patient and Family preferences in care received; clear understanding of patient responsibility for managing health post-discharge; and understanding the purpose of prescribed medications. Inclusion of CTM-3 in the patient experience of care domain is very consistent with successful models of patient care and readmission reduction. We support the inclusion of CTM-3 in the Hospital VBP program.

Additional measures to the Efficiency and Cost Reduction Domain

- **The HQC supports the continuation of the Medicare Spending per Beneficiary measure and also supports development and implementation of additional measures of efficiency in the program.**
- **Additionally, the HQC is encouraged by CMS' efforts to expand the efficiency domain to include a more robust measure set. We suggest CMS introduce a plan illustrating the process for using efficiency measures from the IQR to be included in the hospital VBP program.**
- **We also suggest CMS consider vetting and including the NQF-endorsed cost per episode measures for pneumonia (PN), acute myocardial infarction (AMI) and heart failure (HF) for the Efficiency and Cost Reduction Domain. These measures are all slated for inclusion in the Hospital Inpatient Quality Reporting (IQR) in FY 2017. These measures align with existing quality measures in the hospital VBP program.**

The proposed rule requests comment on adding measures of efficiency to the Hospital VBP program. Currently, the Medicare Spending per Beneficiary (MSPB) is the only measure included in the efficiency domain. This measure is able to capture the efficiency of care provided by hospitals for beneficiaries that are admitted, and provides a good indication of hospital efficiency.

We urge CMS to continue exploring additional measures of cost/efficiency for the program. The HQC recognizes that the value of care provided is a function of both quality and cost, where both elements carry equal weight. The proposed rule includes six possible measures of efficiency proposed to be included the IQR system before inclusion in the Hospital VBP program. The HQC supported the guiding principles for selecting efficiency measures outlined in last year's (FY 2015) proposed rule, which include exploring services linked closely to hospital services, as these services represent a significant share of Medicare payment for hospital care, and have significant performance variation.

We suggest CMS explore using the new cost measures slated for inclusion in the FY 2017 IQR program as potential efficiency and cost reduction domain metrics in the hospital VBP program. Specifically, the following cost of care payment measures are scheduled for inclusion in the FY 2017 IQR program, which may be used in hospital VBP:

- Acute Myocardial Infarction (AMI): Payment associated with a 30-Day Episode-of-Care (NQF #2431) (starts FY 2016)
- Heart Failure (HF): Payment associated with a 30-Day Episode-of-Care (NQF#2436)

- Pneumonia (PN): Payment associated with a 30-day Episode-of-Care for PN (NQF# 2579)

In this proposed rulemaking, CMS is considering other episode-based cost measures for inclusion in the IQR program for FY 2018. These measures have tentative MAP approval pending the NQF-endorsement process:

Medical Episodes
-Kidney/urinary tract infection
-Cellulitis
-Gastrointestinal hemorrhage

Surgical Episodes
- Hip replacement/revision
- Knee replacement/revision
- Lumbar spine fusion/refusion

The HQC is encouraged that CMS is considering additional measures of efficiency but we are concerned that these episodes are not aligned to any other CMS quality initiatives at this point. The specific Medical Episodes have no counter-balancing quality measure and providers may be incentivized to take steps to reduce costs, but CMS will not be able to ensure that quality has not been compromised as a result.

Hospital VBP Measure Domain Weighting

- **The HQC agrees value-based care should be measured in terms of both cost and quality, and believes that cost and quality should be weighted equally. Consistent with this belief, we ask CMS to establish a policy goal and specific plan to incrementally increase the efficiency domain to 50% of the total score as more efficiency measures are developed.**
- **The HQC supports the proposed removal of the process domain completely from the program by FY 2018.**

The HQC has long represented providers, hospitals, and associations who believe that value is best measured by both cost and quality, with each component weighted equally. We supported CMS' decision to increase the weighting of the efficiency domain at 25% of the total score for the FY 2016 program year, but we are disappointed that CMS has not proposed any further increase for this domain. We urge CMS to increase the weight of the efficiency domain to eventually encompass 50% of the program weight.

We appreciate the emphasis in the proposed rule on outcome measures, and support the removal of process measures. In FY 2015 rulemaking cycle, CMS finalized for the FY 2017 program year a weighting of only 5%. for clinical care process measures. We questioned the extent to which process measures are even necessary, given such a low weighting and our view that outcome measures are the best measures for assessing quality. We asked CMS to phase out process measures completely from the program, and we support the current proposal to remove the process domain completely in FY 2018.

E. Hospital Readmissions Reduction Program

In the Hospital Readmissions Reduction (HRR) program, hospitals are compared to average performance of hospitals with similar patient case mix. In FY 2015, 78% of eligible hospitals in the nation were subject to some level of readmissions penalty, which has a statutory ceiling of -3%. To assess hospitals, the current measure set for readmissions include the following: Heart Failure (HF); Acute Myocardial Infarction (AMI); Pneumonia (PN); COPD – Chronic obstructive pulmonary disease; THA/TKA - elective hip and knee replacements; and CABG - Coronary Artery Bypass Graft surgery (for FY 2017).

The HQC supports comprehensive value-based payment policies that not only put payment at risk, but also offer rewards to providers that lead the charge in improving patient experience; improving patient

outcomes, and reducing the cost of care. While the HRR penalties are designed to improve quality and reduce unnecessary spending, the HRR program is a penalty-only program, and does not reward high quality, cost effective care. Further, as structured, the program bases performance on national averages, meaning hospitals may continue to be penalized even if they improve their readmission rates. Finally, the program as implemented is resulting in penalties for a majority of hospitals – 78% of hospitals were penalized in FY 2015, although the average penalties assessed were small. HQC is concerned the program, both in its statutory design and the way it is implemented, is being used as a means to save the Medicare program money, rather than to incentivize value-based reforms. While many of these concerns stem from statutory language, there are refinements that can be made within regulations. The HQC offers the following comments and suggestions to improve the program.

- **CMS should begin steps to assess the feasibility to incorporate sociodemographic factors in risk adjustment methodology through the NQF endorsement process.**

Risk-adjustment is a critical part of any quality and pay-for-performance program. Hospitals should be assessed based on their performance, and their grades should not be influenced by the types of patients they treat. Risk-adjustment helps ensure accurate and fair comparison of patient case mix, taking into consideration severity of illness. In 2006, the National Quality Forum (NQF) established a policy against using sociodemographic factors in risk adjustment methodology for measuring quality of care.[1] However, the NQF policy has been recently revised in 2014 to reflect changing trends in medical care, and is moving through a trial period where sociodemographic adjustment will be applied to select measures, subject to review and endorsement. Given the many input elements to consider in sociodemographics, we believe CMS should consider sociodemographic factors in risk adjustment methodology after careful assessment by the NQF before incorporation into performance programs such as readmissions reduction.

- **Although the HQC supports robust value-based policies, we have concerns about the proposed expanded PN cohort in the readmissions reduction program.**

Effective performance-based payment programs should have clear goalposts, should encourage providers to change their behavior to meet those goalposts, and should result in changes that drive better quality and outcomes. Again, the HQC is concerned the HRR program is a penalty-only program that is being implemented in a way that effectively cuts a majority of hospitals. The penalty formula is flawed because many hospitals will continue to face penalties even as readmission rates decline, and risk-adjustment policy puts hospitals treating large low-income populations at a disadvantage.

For FY 2017, CMS proposes an expansion of patient population (cohort) in the (PN) pneumonia readmission measure. This measure is expanded to patients with: 1) a principal discharge diagnosis of aspiration pneumonia, and 2) principal discharge diagnosis of either sepsis or respiratory failure who also have a secondary diagnosis of pneumonia that is coded as present on admission. The expanded cohort has not yet been endorsed by the NQF, which is also recommended to go through the process by the Measure Application Partnership (MAP).

CMS estimates the proposed changes to the PN cohort would result in the inclusion of over 600,000 (about 65 percent) more patients in the PN measure population. The increased population would raise the national average PN readmissions rate, and affecting individual hospital performance on the measure. According to CMS, the proposed changes would result in a more accurate measure and reduce variation amongst coding

[1]Fiscella, K., Burstin, H.R., & Nerenz, D.R. (2014). Quality measures and sociodemographic risk factors: to adjust or not to adjust. *JAMA, 312*(24). 2615-1616.

practices that assesses performance on the "complete population" of patients receiving treatment for pneumonia.

We would urge CMS not to further increase the PN cohort unless it is made part of a broader value-based program. In addition, this expansion should not be implemented until the policy is endorsed by the MAP and NQF. We strongly support broad, robust value-based programs, and despite the national rate of readmissions is falling, the penalty-only nature of the program should be carefully implemented as to not negatively impact improvement efforts.

G. Hospital-Acquired Condition (HAC) Reduction Program

The Hospital-Acquired Conditions (HAC) Reduction program assesses a 1% penalty for hospitals with the highest quartile rates of infections, injuries, and illness. Per statute, the program must penalize the lowest performing hospitals regardless of the variation in actual HAC rates and regardless of hospital improvement. As designed, the HAC Reduction program will penalize 25% of hospitals every year, even if all hospitals significantly reduce HAC rates. Further, like the Hospital Readmissions Reduction initiative, the HAC program is penalty-only, and does not reward high quality, cost effective care. Outside of these statutory design issues, the HQC is concerned that the program as implemented is not adequately accounting for low-volume hospitals. We offer the following comments on this issue.

- **CMS should revise Standardized Infection Ratio (SIR) methodology or exclude hospitals with low-volumes that may lack sufficient cases to establish an "expected infection" calculation.**

In the HAC program, CMS uses a Standardized Infection Ratio (SIR) to calculate performance with regard to the Infection Prevention component (Domain 2) in the program. From a basic sense, the calculation is "Observed Infection Value/Expected Infection Value." However, when the Expected Infection Value is <1, CMS will deem the ratio invalid, and thus eliminate that part of the HAC program from the overall performance roll-up. All of the weighting criteria then shifts to the other (Patient Safety) domain.

For example, a hospital may not have had a Central Line Associated Blood Stream Infection (CLABSI) for a number of years. But, according to the methodology, because the denominator is less than 1.0 it is removed from the performance calculation as an invalid ratio. Despite the fact that this hospital's performance has been excellent on certain infection measures in Domain 2, all the weighting is shifted to Domain 1, which has been called into question based on reliability analyses. We ask CMS to revise this methodology or exempt those without sufficient cases to take into account low-volume hospitals that may be unfairly subject to imbalanced weighting, and thus, possibly penalized in the HAC program.

Conclusion

On behalf of the HQC, we appreciate the opportunity to continue engaging on these important performance-based programs. If you have any questions or need clarification, please feel free to contact us.

Sincerely,

The Healthcare Quality Coalition