June 16, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS– 1655–P
P.O. Box 8011
Baltimore, MD 21244–1850

Re: Comments on Proposed Rule CMS–1655–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 implementation of the Hospital Readmissions Reduction (HRR), Hospital-Acquired Conditions (HAC), and the Hospital Value-Based Purchasing (VBP) programs as outlined in the Hospital Inpatient Prospective Payment System (IPPS) proposed rule for FY 2017.

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.

G. 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 2016, 2,665 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 (new for FY 2017).

The HQC supports comprehensive value-based payment policies that offer rewards to providers and hospitals that lead in achieving quality 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, 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 – greater than 75% of hospitals were penalized in FY 2016, although the average penalties assessed were small. The 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 take meaningful steps to assess the feasibility of incorporating sociodemographic factors in risk adjustment methodology through the NQF 2 year trial process.**
- **We are encouraged by language in the proposed rule acknowledging ongoing review, but CMS should make a clear statement of intent to carefully consider and support sociodemographic factors in risk adjustment for the HRR program and other value and performance-based programs.**

Risk-adjustment is a critical component 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.

- **Urge caution on further expanding cohorts in readmission measures.**

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 will include 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 that also have a secondary diagnosis of pneumonia that is coded as present on admission.

We would urge CMS not to further increase cohorts in other measure sets unless it is made part of a broader value-based program. We strongly support broad, robust value-based programs, and despite the national rate of readmissions continuing to fall, the penalty-only nature of the program should be carefully implemented as to not negatively impact improvement efforts.

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[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.

H. 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, set to remove process measures and maintaining the weighting of efficiency and cost reduction domain. We also support CMS' efforts to align (but avoid overlap and redundancy) 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

- **The HQC supports continued focus on scoring methodology that rewards value-based care. We are open to proposals on developing measures of "value" so long as they are meaningful, relevant, and reduce the overall measure reporting burden.**
- **The HQC opposes CMS to consider performance scoring methodology that resembles the Physician Value-based Payment Modifier 'Quality Tiering." This approach to scoring resulted in very large, broad categories that create performance cliffs rather than linear-based performance methodology.**
- **CMS should continually assess the improvement aspect of the Hospital VBP program. We fundamentally believe the importance of quality improvement efforts, but close evaluation by CMS is important to determine the extent to which improvement is achieving policy goals. To that end, we suggest CMS incrementally phase out improvement scoring for select measures that have been included for several consecutive years to emphasize comparative achievement performance.**

How value-based initiatives are assessed for performance is a critical policy decision to ensure an effective program is implemented. In the FY 2017 proposed rule, options are considered to modify the way performance is assessed. Currently, in the Hospital VBP program, hospitals report on quality measures through Inpatient Quality Reporting (IQR), measures are assessed and transformed into scores and weighted, with the higher of achievement or improvement used for performance scores. The domain scores are then added up to a total performance score, translated to a percentage using a linear exchange function and converted into a payment adjustment factor. Hospitals that score above 1.00 receive the amount of payment withheld, plus the amount over the threshold.

The FY 2017 IPPS proposed rule provides preliminary discussion on whether to modify the current weighted domain, linear-based scoring methodology. A recent study suggested some hospitals were able to obtain a higher diagnostic related group (DRG) payment (above the withhold) despite scoring poor

on quality measures, but very well on efficiency.[2] This comes to no surprise as for example a hospital may perform (or improve) well in the efficiency and cost reduction and patient experience, but low on outcome measures and still earn a bonus in the program. Because the program for FY 2017 includes 5 measure domains, hospitals can be successful in the program in a number of different ways depending on performance results in the domains.

The HQC opposes the use of the Physician Value-based Payment Modifier methodology for the Hospital VBP program. The scoring methodology in the physician value modifier uses broad categories, known as tiers, to assess performance. Despite physicians and group practices achieving above the average in efficiency and quality, the broad categories resulted in over 85% of physicians and groups as "average" that met Physician Quality Reporting System requirements for participation.

We also encourage CMS to continually assess the improvement scoring aspect of the program. 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, as the program enters it's fifth year of implementation and begins to mature, for measures included in the program for several performance years, the HQC suggests that improvement scoring on select measures should be reassessed and 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. We believe this strikes a good balance between rewarding improvement and achievement.

Hospital VBP Program Measures

- **The HQC supports an increased emphasis on outcome-based quality measures, and removal of measures "topped out," and/or losing NQF endorsement.**
- **The HQC *is concerned that* the proposed CABG 30 day mortality measure is based on limited providers of the service and the potential for bouncing around of the dependency on the measure based on adequate volumes or not.**
- **We support the proposed expanded definitions for CLABSI and CAUTI in FY 2019 and updated PN measure for FY 2021 as they apply to all hospitals equally.**
- **We appreciate the continued focus by CMS on seeking additional measures of efficiency and cost reduction to include in the program and urge such measures balance with a hospital quality metric. In next year's rulemaking cycle, we suggest opening up a wider public comment process on appropriate episode and condition-specific resource use/efficiency measures.**
- **We support the removal of the process measures as previously finalized and the subsequent domain for the FY 2018 program year.**

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[2] Anup Das, Edward C. Norton, David C. Miller, Andrew M. Ryan, John D. Birkmeyer, and Lena M. Chen, "Adding a Spending Metric to Medicare's Hospital Value-Based Purchasing Program Rewarded Low-Quality Hospitals," *Health Affairs* 35, no. 5 (2016): 898-906, doi: 10.1377/hlthaff.2015.1190

- **Although we appreciate the focus on developing additional quality and safety outcome measures and support alignment with other initiatives, we continue to oppose measure that overlap with other related programs, including Hospital Acquired Conditions and Hospital Readmissions Reduction. Overlapping measures with programs outside of Hospital VBP may introduce redundancy, confusion, and contrasting goals.**

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 variation 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.

Additional measures to the Efficiency and Cost Reduction Domain

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 overall provides a broad indicator of hospital spending for admitted patients.

We continue to urge CMS explore 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 HQC supported the guiding principles for selecting efficiency measures outlined in the 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. In addition, we suggest new measures of cost and efficiency be aligned with quality outcomes—that is, measures that provide a link to balance a particular measure with both cost and quality.

At this point, 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. The HQC is encouraged by CMS' efforts to expand the efficiency domain to include a more robust measure set.

In this year's proposed rule, two measures for the efficiency and cost reduction domain are provided: Payment associated with a 30-Day Episode-of-Care (discharge diagnosis plus 30 days post discharge) for Acute Myocardial Infarction (AMI) and Heart Failure (HF). Measures include post discharge payments, including inpatient, outpatient, physician and laboratory services, and are risk adjusted for patient characteristics. Scoring would follow the same methodology as the MSPB measure. We suggest CMS open up new debate for the FY 2018 rulemaking cycle that seeks to broaden the scope of efficiency measures that balance with quality measures, and ensure the measures do not overlap. It is for this reason, the National Qualify Forum (NQF) did not endorse the proposed resource use/efficiency measures.

Proposed additions and modifications to quality measures

The proposed rule seeks to update an existing program measure, the *Hospital 30-day All-Cause, Risk-Standardized Mortality Rate (RSMR) following Pneumonia Hospitalization (NQF #0468).* Through substantial

review, the measure is proposed to expand to new cohorts in FY 2021 that includes: 1) patients with a principal discharge diagnoses of pneumonia; 2) patients with principal discharge diagnosis of aspiration pneumonia; and 30 patients with principal discharge diagnosis of sepsis, with a secondary diagnosis of pneumonia. The measure changes have been incorporated into the Hospital IQR program.

In addition, CMS proposes to add *Hospital 30-day All-Cause, Risk-Standardized Mortality Rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery*. This measure is already included in the IQR program with initial measure data posted on *Hospital Compare* in July 2015.

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 position, we ask CMS to establish a policy goal and specific plan to modify the efficiency domain to equally balance with quality and safety measures attributing to the total performance score.**
- **The HQC supports the proposed removal of the clinical process of care 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. We urge CMS to increase the weight of the efficiency domain to eventually encompass an equal weight with quality and safety domains.

We appreciate the emphasis in the proposed rule on outcome measures, and support the removal of process measures entirely. 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 last year's final rule to remove the process domain completely in FY 2018.

I. 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 please to offer comments on proposed changes for upcoming program years.

Proposed HAC Performance Scoring Methodology Changes

- **Current HAC scoring uses a decile-based system, assigning points based on performance along deciles. The HQC supports the FY 2018 proposed changes in scoring methodology for HAC which would use a 'Winsorized Z-score' method, comparing performance to the national average.**

- **We encourage CMS to seek ways to reevaluate the scoring of Domain 2, aligning with the scoring process in Domain 1, if there are zero adverse events. The absence of measures in Domain 2 (i.e. zero infections) results in the final HAC score being driven by PSI-90 in Domain 1. Unfortunately, the current scoring of Domain 2 is ignoring perfect performance and puts some hospitals at an unfair advantage.**

Based on previous feedback on scoring issues in HAC, including by the HQC, CMS responded by convening a Technical Expert Panel (TEP) to analyze new approaches to improve performance assessment. The TEP identified areas of concern with the decile-based methodology, which assigns points (1-10) on each HQC program measure based on their decile performance. Scores are combined into a domain score, weighted, and summed for a final performance score. The top highest quartile scores (lower are better) are assessed the 1% Medicare payment penalty.

The current scoring approach created issues with performance "cliffs" where a hospital scoring at the lower or upper end of the decile are potentially assessed the same number of points. In contrast, in other situations hospitals without statistically significant differences in performance may be placed in a different decile (one side or another of the particular value). In addition, CMS notes in the proposed rule that using decile scoring resulted in several scoring ties, and as a result CMS did not penalize those hospitals at the 25th percentile, which resulted in a slightly lower number of hospitals penalized (approximately 23%) than the statutory mandate. Finally, to address concerns raised by the HQC in last year's rulemaking, CMS believes the new scoring will be an improvement to hospitals with small amounts of data being unfairly identified as low performers. In fact, in FY 2016 some hospitals which had zero adverse events in PSI measure in Domain 1 and not sufficient amount of data for Domain 2.

The calculation of the proposed formula is as follows:

$$\text{Z-score} = \frac{\text{(Hospitals' Performance — Mean Performance for All Hospitals)}}{\text{Standard Deviation for All Hospitals}}$$

The potential impact of the proposed new scoring will increase the number of hospitals penalized up to the statutory mandate of 25%. According to CMS, 114 hospitals would be brought into the penalty zone while 103 will be removed, and fewer very large and very small hospitals would be penalized overall. Generally, the HQC supports this new proposed methodology, and would urge CMS provide data and reports on which hospitals would be moving in or out of the "penalty zone."

PSI Measure Update for FY 2018

- **The HQC supports the proposed changes to PSI measure in Domain 1 of the HAC program.**

For the FY 2018 program year, CMS proposes to adopt an updated version of PSI 90 measure used in Domain 1. This includes:

- Removal of PSI-7: central venous catheter-related blood stream infection rate
- Addition of PSI-9: Postoperative hemorrhage or hematoma rate
- Addition of PSI-10: Physiologic and metabolic derangement rate
- Addition of PSI-11: Postoperative respiratory failure rate
- PSI 12: now includes extracorporeal membrane oxygenation (ECMO) procedures

- PSI 15: only includes discharges for abdominal/pelvic operations
- Weights no longer solely on volume, but now based on an empirical analysis of volume, excess harm associated with the PSI, and disutility.

Conclusion

On behalf of the HQC, we appreciate the opportunity to provide comments on the FY 2017 Inpatient Prospective Payment System Proposed Rule, engaging on important performance-based programs. If you have any questions or need clarification, please feel free to contact us.

Sincerely,

The Healthcare Quality Coalition