THE HEALTHCARE QUALITY COALITION

June 27, 2014

Centers for Medicare & Medicaid Services
Administrator Marilyn Tavenner
Department of Health and Human Services
Attention: CMS– 1607–P
P.O. Box 8011
Baltimore, MD 21244–1850

Re: Comments on Proposed Rule: Inpatient Prospective Payment System- CMS-1607-P

Dear Administrator Tavenner:

On behalf of the Healthcare Quality Coalition (HQC) we are writing to respond to the request for comments relating to the Hospital Value-Based Purchasing (VBP) Program described in the Hospital Inpatient Prospective Payment System (IPPS) proposed rule for FY 2015.

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, employ more than 21,000 physicians, and have more than 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 VBP Program.

Comments on Hospital Value-Based Purchasing (VBP) Program

The IPPS proposed rule for FY 2015 offers policies related to implementation of the hospital 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 headed in the right direction by emphasizing outcome measures and increasing the weighting of efficiency measures. We also support the Centers for Medicare & Medicaid Services (CMS) in its efforts to align the hospital VBP program with existing hospital and physician quality reporting initiatives, as well as the physician value-based payment modifier. We remain concerned the incentives and penalties under the hospital VBP program are too insignificant to drive real change in hospital quality and cost containment efforts, but understand that the applicable percentages are capped by statute. Below are our specific comments, suggestions, and recommendations regarding the FY 2015 IPPS proposed rule.

Hospital VBP Incentive Funding Pool

- **The FY 2015 proposed rule implements the incremental increase in the amount of payment withheld from all participating hospitals to fund incentive payments.**
- **Although we understand the 2% cap is statutory and cannot be modified through rulemaking, we want to register our view that 2% is not sufficient to drive significant value-based change in the system.**

Current law sets a ceiling of 2% on the amount of Medicare hospital payments subject to withholding and value-based distribution beginning FY 2017. In a study published in *Health Affairs*[1], the researchers suggest the hospital VBP program, as currently structured, is unlikely to cause meaningful reform because incentive payment differentiations were miniscule among 2/3 of hospitals in the program. The HQC recognizes CMS lacks the authority to remove the 2% ceiling, but we want to be clear that this amount will not sufficiently incentivize hospitals to strive toward value-based care delivery.

Hospital VBP Performance Scoring

- **Currently, the Hospital VBP program assesses both performance improvement and achievement, and allows hospitals to do well in the program by either attaining benchmarks or improving on their own performance.**
- **We ecognize the importance of improvement-based scoringfor lower performing hospitals, however, an improvement score may not be appropriate with respect to measures that have been included in the program for a number of years. The HQC recommends that CMS consider incrementally phasing out improvement scoring for select measures that have been included for several consecutive years to emphasize comparative 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 improvement, and the HQC supported the inclusion of improvement incentives at the beginning of the VBP program. However, for measures that have been 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 having the opportunity to improve in newly implemented measures.

Hospital VBP Program Quality Measures

- **The HQC supports an increased emphasis on outcome-based measures, and removal of measures "topped out," and/or losing NQF endorsement.**

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[1] Werner, R.M. & Dudley, R.A. (2012). Medicare's new hospital value-based purchasing program is likely to have only a small impact on hospital payments. *Health Affairs, 31*(9), 1932-1940. doi:10.1377/hlthaff.2011.0990

- **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 believes it is important to align measures across the domains as well as with the physician value-based payment modifier program to the extent practical.**
- **The proposed elective birth measure is considered a good measure of process quality, but this measure has little applicability towards Medicare beneficiaries.**
- **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 measure overlap with the Hospital VBP program.**

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 National Quality Forum (NQF), an important panel of quality experts.

In the FY 2017 program year, CMS proposes to remove six process measures from inclusion in the program. These include the following:

- **PN-6**: Initial antibiotic selection for CAP in Immunocompetent patients
- **SCIP-Card-2**: Surgery Patients on Beta Blocker Prior to arrival received a Beta Blocker during the perioperative period
- **SCIP-Inf-2**: Prophylactic antibiotic selection for surgical patients
- **SCIP-Inf-3**: Prophylactic antibiotics discontinued within 24 hours after surgery end time
- **SCIP-Inf-9**: Postoperative Urinary catheter removal on post-operative day 1 or 2
- **SCIP-VTE-2**: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

The HQC supports removing these "topped out" measures for the FY 2017 program year.

New Measures of Quality

For the FY 2017 program year, the proposed rule suggests new outcome measures for inclusion: Clostridium difficile infection and Methicillin-Resistant *Staphylococcus aureas* Bacteremia. The HQC appreciates the opportunity to comment, and believes other measures of outcomes may be better suited to overall capture outcomes-based quality. 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. Instead, CMS could consider exploring measures related to *Sepsis Mortality* as an alternative outcome measure.

Measures of Efficiency/Cost

- **The HQC supports the Medicare Spending per Beneficiary measure for inclusion in the FY 2015 Hospital VBP program as finalized in prior rulemaking**
- **The HQC also supports development and implementation of additional measures of efficiency in the program.**
- **We are encouraged by the guiding principles for selecting efficiency measures outlined in the 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.**
- **Additionally, the HQC is encouraged by CMS' efforts to expand the efficiency domain to include a more robust measure set. However, we have concerns regarding the proposed medical episode efficiency measures that do not include complementary measures of quality in the program. We suggest CMS consider cost per episode for pneumonia and heart failure, slated for inclusion in the Hospital Inpatient Quality Reporting that align with existing quality measures in the 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 metric is defined as Medicare spending per beneficiary for parts A and B three days prior to a hospital admission through 30 days post discharge, and risk-adjusted for case mix. 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 introduces six possible measures of efficiency, classified as either surgical or medical episodes that need to be approved through the Inpatient Quality Reporting system before inclusion in the Hospital VBP program.

Criteria for selecting conditions for episode measures include, among others, the following:

- Condition constitutes a significant share of Medicare payment for hospitalized patients
- Payments for services provided during the episode can be linked to care provided during the hospitalization
- Episodes of care reflect high-variation in post-discharge payments

The following measures are included for initial discussion and consideration:

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 and we look forward to working with CMS as it continues to develop these and other efficiency measures. But the specific Medical Episodes identified for efficiency, at this point, are not aligned to any other CMS quality initiatives. Additionally, the specific Medical Episodes have no counter-balancing quality measure that is a reflection of value-based care. Without a corresponding quality measure, 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. As such, in FY 2017, CMS will be reporting Cost per Episode for pneumonia and heart failure through the hospital inpatient quality reporting program, and we suggest CMS explore using this as a potential efficiency measure with its scheduled inclusion in the quality reporting program.

Hospital VBP Measure Domain Weights

- **The HQC agrees that value should be measured in terms of both cost and quality, and believes that cost and quality should be weighted equally.**
- **We therefore strongly support the inclusion of efficiency in the program, and support the finalized FY 2016 program year weightings that increase the weight of the efficiency domain by 5% over FY 2015 levels.**
- **Consistent with our belief that quality and cost should be weighted equally in the VBP program, we ask CMS to establish a policy goal and plan to incrementally increase the efficiency domain to 50% of the total score over a period of several years as more efficiency measures are developed.**
- **The HQC also supports the direction CMS is taking with increased weighting for outcome measures, and reduced weighting for process measures.**
- **In the FY 2017 program year, the proposed weight of clinical care process measures is only 5%. We question 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. Thus, we believe CMS should consider phasing out clinical process measures completely from the program.**

Setting domain weights are an important policy decision in implementing the hospital VBP program. 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 support CMS' decision to weigh the efficiency domain at 25% of the total score for the FY 2016 program year, and continue to support a gradual increase of the efficiency domain to eventually encompass 50% of the program weight. Additionally, we appreciate the emphasis in the proposed rule to focus on outcome measures.

The FY 2015 proposed rule revises previously finalized domain weights for the FY 2017 Hospital VBP program:

(1) Safety= 20 percent

(2) Clinical care= 30 percent

   a. Outcomes=25 percent

   b. Processes= 5 percent

(3) Patient and Caregiver Centered Experience of Care/Care Coordination= 25 percent

(4) Efficiency and cost reduction= 25 percent

The HQC supports the alignment of measure domains to the National Quality Strategy by adding the "Safety" domain. However, we question the inclusion of process measures at all if the weight is only assigned 5%, and therefore, support the removal of process measures from the program entirely.

Measure and Program Alignment

The HQC represents hospitals, physicians, integrated health systems and associations committed to value-based care. As CMS continues to develop the Hospital VBP program, we urge officials to seek alignment, to the extent feasible, with the physician value-based payment modifier program. Both of these programs share similarities and it is crucial that measurements and overall program construct are consistent along the continuum of care delivery. As hospitals and clinical services become more intertwined with electronic medical records and quality reporting, aligning the programs while emphasizing patient outcomes helps ensure that providers paid under Medicare Part A and Part B are working in tandem toward the achievement of high-value care delivery.

Conclusion

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

Sincerely,

The Healthcare Quality Coalition