THE HEALTHCARE QUALITY COALITION

June 25, 2013

Centers for Medicare & Medicaid Services
Administrator Marilyn Tavenner
Department of Health and Human Services
Attention: CMS– 1599–P
P.O. Box 8011
Baltimore, MD 21244–1850

Re: Comments on Proposed Rule, Inpatient Prospective Payment System- CMS-1599-P

Dear Administrator Tavenner:

On behalf of the Healthcare Quality Coalition (HQC) we write to respond to the request for comments relating to the Hospital Value-Based Purchasing Program (VBP) described in the Hospital Inpatient Prospective Payment System (IPPS) proposed rule for FY 2014.

Founded in 2009, the HQC supports efforts to create a sustainable Medicare system through cost and quality improvements. We believe value-based policy can both incentivize increased quality and reduce overall costs for the Medicare program. The HQC strongly encourages implementation of a payment system that rewards *value* and are pleased to provide comments on the ongoing policy developments regarding the Hospital VBP program. 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.

Comments on Hospital Value-Based Purchasing (VBP) Program

The FY 2014 IPPS proposed rule offers further developments in the Hospital VBP program. The HQC supports the goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement. In general, the applicability of the hospital VBP program in measuring value-based care is accuracy with endorsed metrics by entities such as the National Quality Forum (NQF), and alignment with existing hospital and physician quality reporting initiatives. Finally, the weight of the hospital VBP program should be sufficient to drive performance efficiencies, modify outdated volume-based care and promote models that focus on high quality, low cost delivery.

Hospital VBP Program Measures

- **The HQC supports moving towards outcome-based measures, and removal of measures "topped out," and/or losing NQF endorsement.**

Overall, the HQC supports the strategic goals of the National Quality Strategy and Centers for Medicare and Medicaid Services (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 is between high and low performers. This approach ensures 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).

Operational alignment

- **The HQC believes it is important to align process measures operationally to outcomes across the domains to the extent possible.**

Within the realm of program measures, we would urge CMS to carefully analyze process and outcome measures to determine alignment with one another. In other words, to what extent do process measures operationally align with measures of outcomes? We believe not only is this important in selecting meaningful hospital measures, but also aligns with the overall goal of providing high quality care. We urge CMS to consider how measures align not only within their respective domains, but across the entire spectrum of the program.

Measures of Efficiency/Cost

- **The HQC supports the Medicare Spending per Beneficiary measure for inclusion in the Hospital VBP program**
- **Additionally, the HQC encourages consideration of additional measures of efficiency, and suggests considering Medicare Total Spending per Beneficiary (Parts A and B) and Medicare Service Utilization for exploring and vetting for potential inclusion in the program.**

Specifically, 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 3 days prior to a hospital admission through 30 days post discharge, 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 performance.

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 quality over cost, where both elements have equal recognition. With that, we suggest additional efficiency measures to be explored in the endorsement process, including: Medicare Total Costs Per Capita; and rates of Medicare Service Utilization.[1]

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[1] See Bankowitz, R. Bechtel, C. Corrigan, J., DeVore, S.D., Fisher, E., & Nelson, G. "A framework for accountable care measures." *Health Affairs.* (2013).

Measure of Medicare total per capita costs reflects the quality of care provided by a hospital to all patients, and captures prevented hospital admissions. Although the MSPB measure analyzes the care made to patients while in the hospital and 30 days post discharge, total costs per capita expands the scope of efficiency to reward hospitals for keeping people out of the hospital beyond the 30 days that the MSPB measures. This data has been frequently used by the Dartmouth Atlas. Additionally, total per capita costs is set to be similarly used in the Physician Value-Based Payment Modifier program.

Measures of Medicare service utilization could also be explored for potential inclusion. This measurement of efficiency utilizes spending data but targets unnecessary and over utilized services for patients with the same conditions across the nation. The Medicare Payment Advisory Commission (MedPAC) has issued periodic reports on Medicare service utilization across regional areas of the U.S. We recommend CMS explore utilization measures that reflect the appropriateness of service use and intensity in hospitals for inclusion in the efficiency domain.

Hospital VBP Measure Domain Weights

- **The HQC supports defining Value-Based Healthcare to include quality and cost measures, with both domains weighted equally.**
- **We support the proposed FY 2016 program year weightings that increase the weight of efficiency, and believe this weight should be incrementally increased to 50% of the total score over a period of 10 years.**

For the purposes of evaluation and scoring under the program, domains categorize measures according to applicability of process, experience, and outcomes. The FY 2015 Hospital VBP program continues to incorporate measures of quality and patient experience but also introduces an efficiency measure. The final FY 2015 program domain weights for hospitals that receive a score on all four categories are as follows:

(1) Clinical process of care= 20 percent

(2) Patient experience of care= 30 percent

(3) Outcomes= 30 percent

(4) Efficiency= 20 percent

For FY 2016, the proposed rule modifies the domain weights to allocate more emphasis on outcomes and efficiency, as follows:

(1) Clinical process of care= 10 percent

(2) Patient experience of care= 25 percent

(3) Outcomes= 40 percent

(4) Efficiency= 25 percent

The HQC strongly supports the proposed rule for Hospital VBP program in FY 2016 by decreasing clinical processes, and increasing outcomes and efficiency measure domains. Furthermore, we urge CMS to continue increasing the weight of the efficiency measure in the domains of the program over a period of 10 years while adding additional measures. This domain represents an important element in the function of value= quality over cost, weighted equally.

Additionally, the proposed rule provides initial options regarding the FY 2017 program domains, illustrated below:

Proposed FY 2017 Domain

(1) Safety= 15 percent

(2) Clinical care= 35 percent

   a. Outcomes=25 percent

   b. Processes= 10 percent

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

(4) Efficiency and cost reduction= 25 percent

The proposed FY 2017 domains are re-structured to align with the National Quality Strategy care domains. Additionally, CMS proposes an alternative domain for FY 2017, which is identical to FY 2016.

Proposed Alternative FY 2017

(1) Clinical process of care= 10 percent

(2) Patient experience of care= 25 percent

(3) Outcomes= 40 percent

(4) Efficiency= 25 percent

The HQC appreciates the preliminary proposals regarding the FY 2017 program, along with the approach of the National Quality Strategy.

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 measurements and overall program construct is congruent within the scope of healthcare 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 services provided under Medicare Part A and Part B are working in tandem for patients and providers.

On behalf of the Healthcare Quality Coalition, 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