June 25, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: [CMS-1694-P]
P.O. Box 8011
Baltimore, MD 21244–1850

Re: Comments on Proposed Rule CMS–1694–P: Fiscal Year 2019 Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals

Dear Administrator Verma:

On behalf of the Healthcare Quality Coalition (HQC), we are writing to respond to the request for comments on the FY 2019 Inpatient Prospective Payment System proposed rule. Our comments focus on the implementation of the "Meaningful Measures" Initiative. In addition, we provide feedback specifically to the quality and value-based programs under Medicare Part A including the Hospital Inpatient Quality Reporting Program (IQR), Hospital Readmissions Reduction (HRR), Hospital-Acquired Conditions (HAC), and the Hospital Value-Based Purchasing (VBP) programs.

The HQC is comprised of hospitals, physicians, health systems, and associations committed to value-based healthcare. Organized in 2009, the HQC supports efforts to create a sustainable healthcare delivery system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall healthcare costs. The HQC strongly supports continued implementation of payment systems that reward value and we are pleased to provide written comments on current quality and performance-based programs.

Overall, the HQC appreciates the efforts on implementing the "Measures that Matter" framework as part of the agency-wide Patients Over Paperwork Initiative[1]. This strategy is directed at identifying the highest priority areas for quality measure and quality improvement to assess the core issues that are essential to improving patient outcomes. The overall goals are to focus on high impact areas and ensure measures are: (1) meaningful to patients, (2) outcome-based when possible, (3) fulfill each program's statutory requirements, (4) align across programs and/or with other payers, and (5) minimize the level

[1]Centers for Medicare and Medicaid. Meaningful Measures. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.

of burden for health care providers. In order to fulfill these goals, CMS has launched 19 Meaningful Measures categories, sorted into six overarching quality priorities. CMS believes the Meaningful Measures Initiative will improve outcomes for patients, families, and providers while reducing burden and costs for clinicians and hospitals. Additionally, CMS concludes they can address cross-cutting measure criteria such as eliminating disparities, safeguarding public health, generate cost savings, and improving rural health.

Overall, the **HQC supports and appreciates the implementation of the meaningful measures initiative,** placing greater value on measuring quality of care focused on outcomes rather than increasing the volume of measures linked primarily to processes. In addition, we are supportive of de-duplication of measures across various programs, eliminating overlap and redundancy. The HQC has advocated for removing measures that are included in multiple programs, and appreciate this strategy in the hospital performance and value-based programs.

Hospital Inpatient Quality Reporting Program & Meaningful Measures Initiative

The Hospital IQR is a quality reporting program. Hospitals that fail to sufficiently report quality measures are subjected to a downward payment adjustment. The IQR has historically been the clearinghouse for measures extracted and applied to performance programs, including HRR, HAC, and VBP.

Measures removal: As part of the meaningful measures strategy, CMS proposes to remove a total of 39 measures from the IQR program for FY 2020 through FY 2023. Of the 39 measures proposed for removal, 18 would be removed from hospital quality programs altogether because they are "topped out" in performance, do not lead to better care or have a costs that outweigh their value. Examples of these measures include two "structural" measures asking hospitals to attest to whether they implement safety culture surveys and use a safe surgery checklist as well as several processes of care measures (e.g., influenza vaccination).

De-duplication of measures across programs: The remaining 21 measures would be "de-duplicated." That is, the measures would be removed from the IQR program, but retained in one of the other hospital measurement programs. In the proposed rule, CMS states that "de-duplication" of measures can remove the burden and complexity of tracking measure performance in multiple programs. Hospitals would still be required to report measure data, and measure results would continue to be publicly reported on *Hospital Compare*. For example, CMS proposes to remove six healthcare-associated infection (HAI) measures from the hospital IQR and hospital VBP programs, but would retain the HAI measures in the HAC program. The existing data reporting requirements for the HAI measures would carry over to the HAC program. Similarly, CMS proposes to remove most of the claims-based 30-day readmission measures from the IQR, but will continue to use them in the HRRP and publicly report the measure results. Overall, we support this approach and direction.

IQR measure additions. The proposed rule seeks comments on adding new measures to the IQR program. These measures were introduced in late 2017 as "Measures under Consideration" for the IQR:

- Claims-Only Hospital-Wide All-Cause Risk Standardized Mortality Measure and the Hybrid version of the measure; and
- Hospital Harm: Opioid-Related Adverse Respiratory Events eCQM

The Hospital-Wide All-Cause Risk Standardized Mortality Measure is claims-based that estimate hospital-level, risk-standardized mortality rate (RSMR) for Medicare Fee For Service patients between the ages of 65 and 94. Mortality is defined as death from any cause within 30 days after the index admission date, including in-hospital deaths. The hybrid version will use Medicare FFS administrative claims to derive the cohort and outcome, and claims and clinical electronic health record (EHR) data for risk adjustment. Mortality rates will be separately calculated and risk adjusted for cases in 13 mutually exclusive service lines, as well as aggregated into a hospital wide rate. The measure is conditionally supported by the National Quality Forum (NQF) Measures Application Partnership (MAP) Workgroup, pending NQF review and endorsement. The MAP recommended the hybrid version undergo a voluntary reporting period before mandatory implementation.

The proposed opioid related adverse respiratory events (ORARE) measure in the hospital setting would assess the rate at which naloxone is administered using a valid method that reliably allows comparison across hospitals. The measure numerator is the number of patients who received naloxone outside of the operating room either: 1) After 24 hours from hospital arrival; or 2) during the first 24 hours after hospital arrival with evidence of hospital opioid administration prior to the naloxone administration. The denominator is all inpatient discharges aged 18+ years old. The NQF MAP Workgroup recommended the measure be refined and resubmitted for consideration because the measure has not been fully tested.

Social Risk Factors. CMS plans to account for social risk factors in the IQR beginning Fall 2018, suggesting that dual eligibility as the best predictor of poor healthcare outcomes among social risk factors tested. Measure rates for certain measures will be stratified by patients' dual eligibility status (Medicare/Medicaid). The first measures will be Pneumonia Readmissions & Mortality as proposed in last year's rulemaking and affect the largest number of hospitals. CMS indicated efforts will be expanded in the future as additional studies are completed. CMS is convening a Technical Expert Panel (TEP) to further solicit feedback from stakeholders on approaches to stratification. Continue work with ASPE, the public, and stakeholders to identify policy solutions that improve health equity while minimizing unintended consequences.

eCQM Reporting, Submission Requirement, and Reporting. For the FY 2021 payment determination, CMS proposes to continue FY 2020 IQR Program requirement. Specifically, hospitals report on a minimum of four self-selected eCQMs from the 15 eCQMs available for the IQR Program. CMS proposes hospitals submit one self-selected quarter of eCQM data from calendar year (CY) 2019. CMS proposes to extend the same eCQM reporting and submission requirements for the Medicare and Medicaid

Promoting Interoperability Program. CMS does not propose any changes to the submission deadlines, sampling, or case threshold policies.

CMS proposes to remove seven eCQMs beginning with the FY 2022 payment determination and subsequent years. CMS also adds that a delay until FY 2022 payment determination would spare hospitals that allocated and expended resources in 2018 to prepare for the CY 2019 reporting period.

By FY 2023, only 22 measures are proposed to remain in the IQR program.

Comments:

- **The HQC supports the overall approach to removing measures that are topped out and de-duplicated across other programs. We also support the expansion of incorporating social risk factors into quality measures.**
- **We would like clarification on the future of the IQR as a measure portal and it's interaction with other performance programs. Would the IQR continue to be a "first step" for ushering new measures into HAC, Hospital VBP, and Readmissions?**
- **The HQC opposes the proposed all-cause readmission and hybrid measure in the IQR.** Hospitals already report and are evaluated on mortality data for high-priority conditions (HF, PN, etc.). Inclusion of this measure set would include this data, making them redundant.
- **The HQC supports the proposed removal of eCQM's. We ask CMS to clarify future plans for eCQM's as they require a significant level of hospital resources to build and implement.**

Hospital Readmissions Reduction Program

In the Hospital Readmissions Reduction (HRRP) program, hospitals are compared to average performance of hospitals with similar patient case mix. For FY 2018 and subsequent years, the reduction is based on a hospital's risk-adjusted readmission rate during a 3-year period for acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG).

CMS proposes no major changes to the HRRP for FY 2019. However, as finalized in the FY 2018 IPPS final rule, CMS will implement the socioeconomic adjustment approach directed by the 21st Century Cures Act. The budget neutral socioeconomic adjustment method, starting for FY 2019 includes dual-eligible patients, the proportion of dual-eligible, and the applicable period for dual eligibility. Hospitals would be placed into five peer groups (quintiles) based on proportion of dual eligible patients from Medicare Parts A and C. A median calculation of the excess readmission ratio for each measure would be performed within the quintiles. CMS would then calculate each hospital's performance versus the quintile median and apply a budget neutrality modifier. The proposed rule

mentions possibility of modifying the peer grouping methodology in the future. CMS also proposes to continue using a three-year performance period for the HRRP (i.e., July 1, 2014 – June 30, 2017).

CMS estimates that 2,610 hospitals would have their base operating DRG payments reduced by their determined proposed proxy FY 2019 hospital-specific readmission adjustment and the cost savings to the HRR would be approximately $566 million in FY 2019. As a penalty-only adjustment, from FY 2013 through FY 2018, the aggregate payment impact of the HRR program is approximately -$2.5 billion.

Comments:

- **The HQC supports socioeconomic risk adjustment in hospital performance programs.**
- **We generally support the specific proposed readmissions socioeconomic adjustment methodology, placing hospitals into five peer groups based on proportion of dual eligible patients, including Medicare fee for service, and Medicare Advantage populations. We ask continued evaluation and refinement be conducted as experience grows with this type of risk adjustment.**
- **We ask that socioeconomic risk adjustment be implemented across all quality improvement and pay-for-performance initiatives.**

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP program began in October 2012 as an pay-for-performance incentive withhold and redistribution program. This is the only CMS pay-for-performance program with a financial upside or potential for bonus. Currently, the program hospitals report on quality measures through the 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 HQC supports the overarching goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement. Overall, we appreciate CMS' efforts to align and de-duplicate measures across hospital reporting and performance programs. 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 in the program has been minimal. 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.

The FY 2019 proposed rule contains a number of performance measure changes. CMS is proposing a removal of ten measures from VBP, but would be continued in the Hospital IQR Program or the HAC

program. As part of de-duplication efforts, the purpose is to reduce the administrative burden of tracking these measures in multiple programs.

CMS plans to remove 4 initial measures for FY 2019:

1. Patient Safety and Adverse Events (Composite) (NQF #0531) (PSI 90)
2. Hospital- Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction (NQF #2431) (AMI Payment)
3. Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Heart Failure(NQF #2436) (HF Payment)
4. Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Pneumonia (PN Payment) (NQF #2579)

In addition, CMS plans to remove six measures in FY 2021:

1. Elective Delivery (NQF #0469) (PC-01)
2. National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
3. National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)
4. American College of Surgeons-Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753)
5. National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* Bacteremia (MRSA) Outcome Measure (NQF #1716)
6. National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717).

CMS is also proposing to remove the Safety domain entirely from the Hospital VBP Program. If this proposal is finalized, scoring for the remaining domains will be Clinical Outcomes domain (renamed from Clinical Care) – 50 percent; Person and Community Engagement domain – 25 percent; and Efficiency and Cost Reduction domain – 25 percent.

Overall, the HQC supports the strategic goals of the National Quality Strategy and CMS in transitioning the program towards 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.

Measures of Efficiency/Cost. In prior rulemaking, CMS adopted two condition-specific episode-based payment measures (AMI and HF) for the FY 2021 VBP program adding to the Medicare spending per beneficiary (MSPB) measure already in the program. In this proposal, the episode/condition-based measures are removed. As a result, the MSPB measure would comprise the entire domain.

We continue to urge CMS to explore additional measures of cost/efficiency for the program that carry a counterbalance with quality measures. We are concerned with the proposed removal of previously finalized cost measures. Instead of relying solely on MSPB, We suggest CMS introduce a plan for using additional efficiency measures for inclusion in the hospital VBP program so long as they balanced with quality outcome measures.

Domains and Weights. Starting FY 2021, the Hospital VBP domains will be collapsed and modified. First, the "Safety" Domain will be eliminated with the measures removed from the program. Second, Clinical Care category will be changed to "Clinical Outcomes" and will constitute 50% weight, absorbing the weight of the removed Safety domain and is proposed to weigh the greatest with the most measures. Finally, "Efficiency and Cost Reduction", along with "Person and Community Engagement" will be each weighted at 25% respectively. As an alternative, CMS proposes to weigh each category equally at 33%.

Comments on the Hospital VBP Program

- **The HQC continues to support an increased emphasis on outcome-based quality measures, and removal of measures "topped out," and/or losing NQF endorsement. We appreciate the proposed de-duplication policies and the Meaningful Measures framework.**
- **As a guiding principle, the HQC supports cost measures that have a counter balancing quality component as a best reflection of value-based measurement. Spending measures should be coupled with a quality measure within hospital VBP to provide a clear, meaningful picture of value-based care delivery.**
- **As such, the HQC is concerned about the removal of episode-based cost measures and relying solely on Medicare Spending per Beneficiary (MSPB). As we have commented in the past rulemaking cycles, we have asked for additional measures of efficiency, and CMS responded. However, moving back to a single, broad spending measure carries significant weight as a sole measure in a domain. The measure itself can be difficult to operationalize at the service line level where targeted quality improvement efforts are frequently dispatched.**
- **The HQC has long supported equal weights of performance domains and would support the proposed alternative methodology if CMS implements previously finalized additional measures of efficiency/cost. This would better balance hospital performance.**

Hospital-Acquired Condition (HAC) Reduction Program

The Hospital-Acquired Conditions (HAC) Reduction program assesses a 1% Medicare payment 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 reduce infection rates. The HQC opposes a penalty-only program on the grounds of advancing value through incentives and improved community health rather than arbitrary penalty assessments. Further, like the HRR 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 pleased to offer comments on proposed changes for upcoming program years.

Scoring Methodology. No proposed changes to z-scoring methodology, or determination of the 75th percentile. CMS does request comment on two alternative scoring methodologies for calculating Total HAC Scores in efforts to address concerns about the disproportionate weight applied to Domain 2 measures for low-volume hospitals.

CMS proposes to change the HAC scoring methodology by eliminating measure domains and assigning an equal weight to all six performance measures in the program. The remainder of the scoring methodology would remain unchanged. CMS believes this change would address the concerns expressed by stakeholders who believed it was problematic for their HAI domain scores to rest on the performance of only one or two measures. CMS prefers the Equal Weighting option. This methodology removes domains and equally weighs measures that have scores (will vary from 16.7% if all measures have scores to 100% if only one measure has a score). CMS suggests this will be easier approach if and when new measures are added and estimates that the approach should penalize slightly fewer smaller hospitals. However, the agency also estimates that the approach may penalize slightly more teaching hospitals and large urban hospitals.

A secondary approach would apply weights variably. Retain domains and assigns weights dependent upon the number of measures that have scores in each domain (Domain 1 could range from 0-100% and Domain 2 could range from 0-100%, each measure ranging from 60% to 20%). Under this method, domain weights would vary by hospital.

Reporting Modifications. Because CMS has proposed to remove all of the HAI measures in the HAC Reduction Program from the hospital IQR program, it must establish data reporting and validation requirements within the HAC Program. CMS proposes to carry over nearly all of the same requirements used in the IQR program to the HAC program. CMS notes that any hospitals that fail measure validation would receive the lowest possible score on the selected measures.

Program Measures. CMS is requesting public comments and suggestions for additional program measures, specifically whether eCQMs will improve the program in the future:

- Would eCQMs improve measurement of processes, observations, treatments, and outcomes?
- Would eCQMs reduce burden? Are they less resource intensive? Less likely to produce error?

Comments on the HAC Program

- **The HQC appreciates focus on address ongoing issues with hospitals subjected to the HAC penalty with low volumes, where their HAC entire score is limited to a single domain. As such, the HQC supports (Equal Weight or Variable Weight or Other) method of program scoring that best addresses these concerns.**

Conclusion

On behalf of the HQC, we appreciate the opportunity to provide comments on the FY 2019 Inpatient Prospective Payment System Proposed Rule. Overall, we are pleased with the direction on focusing measures that matter for patient care and quality improvement. If you have any questions or need clarification, please feel free to contact us.

Sincerely,

The Healthcare Quality Coalition