December 5, 2014

The National Quality Forum
Measure Applications Partnership (MAP) Coordinating Committee
1030 15th Street NW
Suite 800
Washington DC 20005

Attention: Committee Co-Chairs
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

Re: 2014 Measures Under Consideration (MUC) Comments

Dear MAP Coordinating Committee Members:

The Healthcare Leadership Council (HLC) respectfully submits these comments in connection with The Centers for Medicare & Medicaid Services (CMS) issued List of Measures under Consideration (MUC) (the List) to comply with Section 1890A(a)(2) of the Social Security Act (the Act), which requires the Department of Health and Human Services (DHHS) to make publicly available a list of certain categories of quality and efficiency measures that it is considering for adoption through rulemaking for the Medicare program.

In this response, we (i) provide background on HLC and (ii) offer a response to the request for early public comments for the 2014 Measures Under Consideration (MUC) as well as broad public feedback to guide the individual MAP workgroups in their deliberations process.

Background

HLC, a coalition of chief executives from all disciplines within American healthcare, is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century system that makes affordable, high-quality care accessible to all Americans.

Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, and information technology companies – envision a quality-driven system that fosters innovation. HLC members advocate measures to increase the quality and efficiency of American healthcare by emphasizing wellness and prevention, care coordination, and the use of evidence-based medicine, while utilizing consumer choice and competition to elevate value.

Comments

The Affordable Care Act (ACA) made major changes to the Medicare program. These changes will move our healthcare system away from a payment system that pays providers for the volume of services to one that rewards providers, in part, based on the quality and outcomes of their services. As a result of the ACA, six percent of hospitals' payments will be subject to a performance standard: three percent for hospital readmissions, two percent for value-based purchasing, and one percent for hospital-acquired conditions (HAC).

Medicare's Hospital Readmission Reduction Program (HRRP) links risk-adjusted hospital readmission rates to financial penalties. Hospitals with risk-adjusted readmission rates that fall below the national average are penalized by having their annual Medicare payments reduced by up to three percent. In 2015, hospital payments are scheduled to be reduced by up to three percent. In FYs 2013 and 2014, hospitals that exceed expected readmission rates for heart attack, heart failure and pneumonia have payments for all DRGs reduced by up to one and two percent, respectively. For FY 2015 and subsequent years, hospitals with higher than expected readmission rates for these conditions, as well as chronic obstructive pulmonary disease (COPD) and elective total hip/total knee arthoplasty will have their payments reduced by up to three percent. Risk adjustment is one way to statistically control for factors that lie beyond a provider's scope of care. HRRP currently applies a risk adjustment formula[1] that includes factors such as a patient's gender, age and health status, but does not include what are referred to as social determinants of health that are captured in a patient's socioeconomic status (SES) with factors such as income and education.

The Hospital Readmission Reduction Program has only one measure currently under consideration. HLC is concerned that pay-for-performance penalties are having a disparate impact on hospitals that serve low-income areas. More than any other hospital metric, readmissions are influenced greatly by factors beyond the hospital's control, and studies have demonstrated that the challenges faced by urban and rural low-income populations directly impact these outcomes. Numerous analyses have found that safety net hospitals[2], which care for low-income patients, are more than twice as likely to be penalized as hospitals caring for higher-income patients. After controlling for quality of care, hospitals serving large shares of low-income patients consistently have higher readmission rates than their wealthier peers. Low-income patients often lack the support to keep them out of the hospital and/or to help them become healthier. This is due to a myriad of issues, including: weaker social networks, cultural and linguistic challenges, high levels of homelessness, high illiteracy rates, and poor access to auxiliary health care services and pharmacies. A hospital's readmission performance is calculated using NQF-endorsed risk-adjusted 30-day measures for AMI, heart failure and

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[1] QualityNet, *Measure Methodology Reports: Readmission Measures* *http://www.qualitynet.org/dcs/ContentServer?cid=1219069855841&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page*

[2] The Commonwealth Fund Issue Brief, *Hospital Readmissions: Measuring for Improvement, Accountability, and Patients* *http://www.commonwealthfund.org/~/media/Files/Publications/Issue Brief/2013/Sep/1703_Marks_hosp_readmissions_ib_FINAL_v3.pdf*

pneumonia. NQF recognized that outcomes are influenced by many factors other than care and services received, so there are adjustments for clinical factors such as comorbidity and severity of illness. However, these measures do not adjust for the socio-economic status of the hospital's patient population. NQF has recognized the possible consequences of this omission and has published a report suggesting socio-economic risk adjustment for certain quality measures where there is a conceptual relationship and an empirical basis.

HRRP penalties can be significant and add to the financial challenges already facing safety net hospitals. HLC is concerned that this may lead to unintended consequences, such as hospital closures in areas where few providers operate – which in turn, could worsen health disparities rather than alleviate them among Medicare beneficiaries who live in low-income areas. Given the potential for inadvertent consequences, pay-for-performance programs must be carefully designed to ensure at a minimum that health disparities are not exacerbated. Programs should accurately measure the performance of providers for whom payments are put at risk while controlling for factors that are outside a provider's sphere of influence. In the case of hospital readmission rates, the scope of the quality measure (rate of readmissions 30 days after hospital discharges) is too broad to isolate the effect of a hospital's role because many significant social and demographic factors come into play after discharge.

The Medicare Payment Advisory Commission (MedPAC) is considering a new approach to measuring and reporting on the quality of care within and across the three main payment models in Medicare: Fee-For-Service Medicare, Medicare Advantage, and Accountable Care Organizations (ACOs). In MedPAC's June 2014 Report[3] the Commission remarked on an initial study of the feasibility of calculating population-based outcome measures for Medicare, in which they worked with a contractor to calculate rates for potentially preventable admissions (PPAs) and potentially preventable visits (PPVs) to emergency departments. The results of that initial analysis indicated that it is feasible to use FFS Medicare claims data to calculate rates of PPAs and PPVs. These rates demonstrate that Medicare could set a more specific performance benchmark in each local area.

Additionally, NQF draft recommendations would require CMS to account for patient socio-economic status when calculating the risk-adjusted readmissions penalties. The National Quality Forum's Technical Report issued August 15, 2014, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*, stated that: "There is a large body of evidence that various sociodemographic factors influence outcomes, and thus influence results on outcome performance measures. There also is a large body of evidence that there are disparities in health and healthcare related to some of those sociodemographic factors. Given the evidence, the overarching question addressed in this project is, "What, if anything, should be done about sociodemographic factors in relation to outcome performance measurement?"[4]

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[3] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, Measuring quality of care in Medicare, June 2014

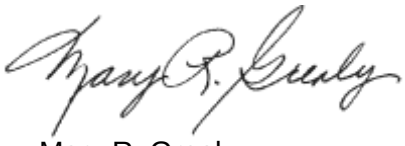
[4] National Quality Forum, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors: Technical Report*, August 15, 2014

This project did not include recommendations for specific performance measures: adjustment for determining payment for services provided, such as capitated payments; use of particular risk adjustment or statistical procedures; or structuring performance/reward penalty programs such as pay-for-performance. It recommended that the NQF should define a transition period for implementation of the recommendations related to sociodemographic adjustment.

The CEOs of the Healthcare Leadership Council are strongly committed to reducing unnecessary readmissions to our nation's hospitals, and believe that hospitals should be held accountable for the quality of their care. However, we urge the MAP Committee to consider measures that will ensure hospitals serving low-income populations are evaluated and reimbursed fairly. Including patients' socioeconomic status as part of the list of measures under considerations can improve the quality of care, increase payment accuracy for all inpatient hospitals, and better manage patients affected by factors outside the hospital's control.

HLC appreciates this opportunity to comment on the Measures Under Consideration. We believe there is tremendous potential for the health care industry as a whole to bring about robust collaboration and quality improvement in Medicare and Medicaid, both of which will be critical to achieving our mutual goal of improving the value of healthcare delivery for all.

Sincerely,



Mary R. Grealy
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