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| 8/22/2011 | Thank you for your rigorous and transparent approach to readmissions measure development.<br>Yours will become the gold standard for this measurement, I am sure.<br><br>My only question: Are you using "present on admission" (POA) coding as part of your risk adjustment modeling scheme? In other words, does a condition that is present on index admission feed into the risk adjustment model? Or, as is implied in your document, are you relying on coding during prior encounters to identify the POA condition(s)?<br><br>Thank you again for your thoughtful work. | Martha J. Radford, MD<br>Chief Quality Officer, NYU Langone Medical Center<br>Professor of Medicine (Cardiology), NYU School of Medicine | Hospital/ health system |
| 8/23/2011 | Of particular importance is the risk adjustment methodology and ensuring 1. The hospitals actually know what the CMS methodology is (which they currently do not) and 2. all evidenced based valid factors go into the risk model adjustment.<br><br>For instance it has been shown that patients discharged to SNFs have a 20-30% greater likelihood to be readmitted within 30 days and those discharge to home-care services have a 15-20% greater likelihood to be readmitted than those discharged without needing services. Are these independent risk factors that ought to be included in the mix or are they reflective of their severity of illness? I bet that given the same morbidity list, those in SNFs and those requiring home-care are more likely to be readmitted.<br><br>In addition, I object to the all-cause readmission approach. What is the purpose? The readmission should somehow be linked to the index admission, as it is in the 3M methodology currently being utilized in New York State. | Steven Silber, DO, ScM<br>Vice President for Medical Affairs<br>Chief Medical Quality Officer<br>New York Methodist Hospital | Hospital/ health system |
| 8/23/2011 | A few thoughts from Fox Chase Cancer Center, Philadelphia, PA:<br>• Inclusion and exclusion criteria – would like to see scheduled readmissions excluded from database. For example, at Fox Chase Cancer Center a fairly substantial number of our patients are SCHEDULED to be readmitted for surgical procedures, chemotherapy treatments, etc. and we should not be penalized for these readmissions. When we started looking at readmissions, I asked that this report get modified to exclude any DRGs that involved specific planned surgical procedures, chemotherapy. This has helped us get a truer sense of AVOIDABLE readmissions, and we are now conducting root cause analyses on all 30 day readmissions to identify our opportunities for improvement in care.<br>• Definition of the cohort, in particular the organization into cohorts of conditions – would love to see that the NCI-designated comprehensive cancer centers are considered as a separate cohort for this measure so we can more appropriately benchmark our readmission data.<br>• Definition of planned readmissions – scheduled chemotherapy treatment, scheduled surgical procedures that were not a result of post-discharge complications<br>• Risk-adjustment, in particular the final choice of covariates – agree that some risk adjustment would be necessary to account for different patient populations – for example elderly patients with chronic diseases, have a higher likelihood of readmission, then a younger, healthier patient population. Somehow, comorbidities and skill mix index need to be taken into account.<br>Thank you, we look forward to hearing more. | Anne Jadwin, RN, MSN, AOCN, NE-BC<br>Assistant Vice President of Nursing Services<br>Fox Chase Cancer Center | Hospital/ health system |

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| 8/23/2011 | Medical Center Health System is located in West Texas and covers 60,000 square miles and a population of 500,000 people. We are affiliated with Texas Tech University Health Science Center of the Permian Basin and have 63 residents in FP/IM and OB/Gyn that admit around 25% of 13,000 admissions for 31 faculty. We have a fully operational hospitalist program that admits around 30% of 13,000 admissions for 49 contracted docs. We have a Medical Staff of 300 physicians in all specialties.<br><br>I have been following all of our readmissions from July 30 2011 through August 21 2011. I have contacted the re-admitting attending to question if the "readmission was for the same diagnosis and/or a staged surgical procedure?" The results follow:<br>1. 78 readmissions and all physicians contacted for a response to the question.<br>2. Responsible attending specialty for readmissions: 8 by Surgeons; 21 by IM/FPs; 14 by Hospitalists; 1 by a Pediatrician; 28 by Faculty/Residents; 3 by OB/Gyn; 3 by Oncologists<br>3. 38 physician responses answering the question, 40 non-responders<br>4. Of the 38 responses 6 readmissions for the same diagnosis within 30 days<br>5. Of the 38 responses 1 readmission for a staged surgical procedure, staged subdural hematoma evacuation<br>6. Of the 38 responses 1 readmission for a complication of an ortho implant device (an unexpected staged surgical procedure)<br>7. Of the 78 readmissions 12 that could have had more detailed admitting diagnosis<br>8. Thus, 70 readmissions for a different diagnosis<br><br>Thus, my response to CMS depends on this being a similar situation among the American Hospitals Nationwide, this does not account for readmissions to another local neighboring hospital nor another hospital in Midland County. From 23 days data a lot of effort has gone into following the readmissions. Six actually being readmitted for the same diagnosis including:<br>a. Subdural hematoma<br>b. Ethanol intoxication<br>c. Urinary tract infection with bacteremia<br>d. Recurrent COPD<br>e. Recurrent Chest pain prior to outpatient work-up by stress test and echo cardiogram<br>f. Recurrent ascites<br>None of the above I see being altered by intervening in the patient's life style via Medical Home or some similar endeavor.<br><br>I believe this brief synopsis speaks for itself. I'd encourage CMS to reconsider its "all readmission" stand and although it is costing the US economy much, the experience above does not seem alterable regardless of the intensity of the effort or follow-up with the patients Primary Care Physician. | Bruce Becker MD, FACHE, FACPE, FAAFP<br>Chief Medical and Quality and Patient Safety Officer<br>Medical Center Health System | Hospital/ health system |

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| 8/26/2011 | Thank you for the opportunity to comment on the proposed hospital-wide all-condition 30-day readmission measure. We acknowledge the considerable effort and thoughtfulness that went into creating this measure and have the following suggestions for improving its accuracy and acceptance by the medical community:<br>1. Re: inclusion and exclusion criteria, we strongly urge CMS to consider excluding patients who have undergone bone marrow or other organ transplants from this measure. This unique population of immunosuppressed patients frequently utilizes inpatient care and is concentrated in a small number of teaching hospitals. Given that existing risk adjustment methodologies cannot reliably adjust for the severity of illness in such patients, including them in a hospital-wide readmission measure will unfairly favor hospitals that do not usually care for transplant recipients. We do not believe that including covariates designating transplant status in regression models is sufficient to adjust for this stark difference between the small number of teaching hospitals caring for the majority of transplant recipients and all remaining US hospitals.<br>2. Re: inclusion and exclusion criteria, for the reasons cited above, we would also recommend excluding patients with left ventricular (cardiac) assist devices and cystic fibrosis from this readmission measure.<br>3. Re: inclusion and exclusion criteria and the final choice of covariates, although the YNHHSC/CORE team has included a condition-specific indicator (AHRQ CCS) in their regression models, this is insufficient to adjust for the higher severity of illness of patients transferred to teaching hospitals after all therapeutic options have been exhausted in the community hospital setting. Excluding transferred patients from this measure is the only reliable way to keep from unfairly favoring community hospitals over teaching hospitals.<br>4. Re: inclusion and exclusion criteria, it is likely that some patients will continue to be readmitted multiple times due to non-compliance with medical advice or medical therapy. CMS can avoid penalizing hospitals for patients' non-compliance by excluding patients with documentation of non-compliance in the medical record, ICD-9 code V15.81.<br>5. Re: organization into cohorts of conditions, please consider reclassifying the following condition categories under the surgical/gynecological cohort: 136 disorders of teeth and jaw, 142 appendicitis and other appendiceal conditions, 143 abdominal hernia, 162 other diseases of bladder and urethra, 164 hyperplasia of prostate, 169 endometriosis, 170 prolapse of female genital organs, 174 female infertility, 225 joint disorders and dislocations/trauma-related, 228 skull and face fractures, 230 fracture of lower limb, 231 other fractures, 235 open wounds of head/neck/trunk, 236 open wounds of extremities, 240 burns, and 244 other injuries and conditions due to external causes.<br>6. Re: organization into cohorts of conditions, if condition category 56, cystic fibrosis, is not to be excluded from the measure then please consider reclassifying under the cardiorespiratory cohort instead of general medicine.<br>7. Re: definition of planned readmissions, we have serious reservations about the proposed methodology. Although the two main principles that underpin the selection algorithm seem reasonable, narrowing the list of procedures from AHRQ's 231 categories down to only 32 "typically planned procedures" seems like an oversimplification. Several procedures that could potentially be planned are excluded from this list, for example: 2 insertion/replacement or removal of extracranial ventricular shunt, 72 colostomy temporary/permanent, 73 ileostomy and other enterostomy, 75 small bowel resection, 87 laparoscopy (GI only), 89 exploratory laparotomy, 90 excision/lysis peritoneal adhesions, 101 transurethral excision/drainage or removal urinary obstruction, 127 dilatation and curettage or aspiration after delivery or | Omar Hasan, MBBS, MPH, FACP<br>Medical Director, Continuum of Care Strategies<br>Brigham and Women's Hospital | Hospital/ health system |

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| | abortion, 169 debridement of wound/infection/burn, and 222 blood transfusion.<br>8. Re: definition of planned readmissions, we recommend excluding the following condition categories from the list of 26 discharge conditions categorized under "acute or complications of care": 105 conduction disorders, 106 cardiac dysrhythmias, and 160 calculus of urinary tract. It is possible for a patient to have a planned readmission for insertion/revision/replacement/removal of cardiac pacemaker or cardioverter/defibrillator (procedure category 48) under condition category 105 or 106 and applying this exclusion in the selection algorithm may erroneously classify such a readmission as unplanned. Similarly, it is possible for a patient to have a planned readmission for transurethral excision/drainage or removal urinary obstruction (procedure category 101; see comment # 7 above) and be misclassified as unplanned if the condition category 160 exclusion is applied.<br>We support the creation of appropriate performance measures by CMS and appreciate this opportunity to participate in measure development. | | |
| 8/26/2011 | On behalf of the over 79,000 member physical therapists, physical therapists assistants, and students of physical therapy of the American Physical Therapy Association (APTA), I would like to submit the following comments regarding the Draft Measure Methodology Report for Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure. Physical therapy is an integral service across multiple settings including the inpatient setting, and therefore we are concerned about the proposed measure methodology.<br><br>**<u>Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure</u>**<br><br><u>Methodology:</u><br><br>APTA applauds YNHHSC/CORE for developing a Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure (HWR) which attempts to segregate out planned readmissions from those that are unplanned. The ability to identify unplanned readmissions is critical to addressing quality of care issues and improving the healthcare delivery system. We are pleased to see the incorporation of several other concepts in the HWR methodology including: risk-adjustments with exceptions for complications of care, recognition of "high competing mortality risk condition" categories, exceptions for "rehabilitation care; fitting of prostheses and adjustment devices", and the use of condition stratified models within the measure.<br><br>APTA does have concerns about the application of the HWR measure in the current pay-for-performance environment. APTA is concerned that the incorporation of the HWR measure into settings in which condition specific readmission measures (acute myocardial infarction, heart failure and pneumonia) are currently being utilized for pay-for-performance will result in a "double jeopardy" payment penalty situation as the HWR measure also includes these diagnoses in the methodology. For instance if a hospital sees a high volume of heart failure patients and has a high readmission rate for these patients 2 they could be penalized for their performance under the individual measure and the HWR measure.<br><br><u>Public Comment Solicitation:</u> | R. Scott Ward, PT, PhD<br>President<br>American Physical Therapy Association | Medical Professional Association |

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| | While we appreciate having the opportunity to submit comments on the draft report, APTA would like to voice our concerns with the short turnaround time for public comment on the methodology for the 30-day risk adjusted readmission measure. The draft measure methodology report was finalized on August 10 and public comments were due by August 29, a very short time frame for comment. Stakeholders would be able to provide more thorough and meaningful comment if notice of the opportunity to comment was announced more publicly and a longer time frame for review and comment were allowed. APTA strongly recommends that this feedback be given to the Centers for Medicare and Medicaid Services (CMS) as we feel it is essential to allow for public comment on measurement methodology reports as these methodologies, once finalized, will be utilized in quality reporting and payment penalties in a variety of settings.<br><br>**Conclusion**<br><br>Despite APTA's concerns about the public comment process for the HWR measure methodology, we believe strongly that the utilization of this readmission measure and other quality measures will serve as vehicle for improving patient safety and outcomes. In closing, APTA thanks YNHHSC/CORE for the opportunity to provide comments on the Draft Measure Methodology Report for Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure. APTA looks forward to working with the CMS in the implementation of this and other quality measures in the inpatient setting that will promote improved quality in health care. If you have any questions, please feel free to contact Heather Smith, Associate Director of Quality Initiatives, at [redacted] or [redacted]. | | |
| 8/28/2011 | I really enjoyed reading this draft report; even in the (not inconsiderable number of) places where I disagree, it is generally clearly written and easy to discuss.<br>1. **Glossary**. This is an unusually important section of this particular report because strict adherence to nomenclature helps the reader to avoid many potential misunderstandings. I recommend going back and assuring that you have used the defined word or phrase every time (for example, the isolated word admission could mean either an index admission or a readmission, and sometimes that confused me; likewise, sometimes you use the term risk factor and sometimes the term risk variable and sometimes, if I understand your language, covariate).<br>2. **Approach to Measure Development** (1.3): I think it would be helpful to the reader to place in your introduction, or the beginning of your methods section, a list, perhaps even a brief discussion, of issues that are beyond the scope of your analysis. I think it likely that you will feel that several of the issues I raise below go in this category.<br>3. **Outcome Definition** (2.2)<br>a. Planned Readmissions (2.2.1) This section does a very nice job with planned procedures and chemotherapy. What it does not deal with is the discharge for planned observation – that is, for example, the patient who is discharged with COPD and with an understanding that the treatment regimen may fail and the patient be returned to the ED in acute distress. I am not arguing here that such readmissions should not count; rather, I think there needs to be some explicit language that explains the decision not to exclude them.<br>b. Thirty-Day Timeframe (2.2.2) This section does not make a persuasive case for the 30-day frame. I do not believe that there is any science to support 30 days in the references you cite; indeed, several of those references suggest or show that the readmission curves for intervention and | Stephen F. Jencks, M.D., M.P.H.<br>Consultant in Healthcare Safety and Quality | Health consulting |

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| | control groups continue to diverge after 30 days. The 30-day window really looks more like an effort to balance a short enough period so that hospitals are not outraged by accountability against a long enough period to provide sufficient numbers to differentiate hospitals. The 30-day window for mortality, by the way, is completely different in origin (designed to assure that very few patients remained in the hospital) and fairly different in application (from admission rather than discharge). The statement that "curves typically stabilized within 30 days of discharge" is very difficult to support from the time-to-event curves provided. The rate of readmission declines steadily and substantially from 30 days to 90 days after discharge – by visual inspection, the rate between 60 to 90 days is roughly but uniformly less than the rate from 30 to 60 days. The curves plotted are not the best way to make the distinction – they plot survival (percent not admitted) over time; your assertion that things have stabilized is a statement about the rate of change and to document that you should plot the readmission rate against time. This brings us to a more general concern about the time window. It seems to me that you should at least carefully consider the merits of replacing the dichotomous 30-day outcome with survival or event modeling for clinical (30 days has little clinical persuasiveness), administrative (you do not wish to incentivize delaying readmissions from day 29 to day 31), and statistical (somewhat more power per observation and more fluent handling of incomplete data) reasons.<br>c. All-cause Readmission (2.2.3) Your argument for using all-cause readmissions is persuasive and the arguments generally correct. However, I might emphasize that readmitted patients almost all have multiple conditions and that those caring for them are often playing clinical whack-a-mole in which any kind of systems failure is likely to be catastrophic in ways only related to the index admission if you know the patient.<br>4. **Exclusions** (2.3) I think the discussion of exclusions would benefit from balancing the case for exclusion, which you make, against the case for inclusion, which you generally do not report.<br>b. AMA discharges. AMA discharges are not events like lightning strikes that are beyond the hospital's control. Examining distribution shows heavy concentration in some states and some facilities. Hospital policy plays heavily in whether a patient who wishes to leave is labeled AMA or whether the hospital works with that patient to find a workable solution. The medico-legal environment also appears to play. I would suggest that, at a minimum, you make AMA a risk factor rather than excluding the patients.<br>c. Rehabilitation. This argument is not quite right. The only readmissions you are counting are to acute care hospitals, and there is a DRG for rehabilitation with a significant number of patients in it. I wonder whether you are making an argument to not count readmissions for rehab because they are planned (and if not, why not?) rather than to not count rehab index admissions. At a minimum, you need to be much clearer.<br>d. Competing mortality. I would like to make a case for including these patients. I would describe a patient with these diseases dying without readmission is most likely a clinical and discharge planning success for the patient and family. The competing practice is to admit everyone who is dying, and I believe we are past seeing that a desirable. Excluding these patients removes a subpopulation with very important discharge/transition planning needs, and does so for reasons that are unpersuasive. If you want to treat death as a censoring event (see my argument above about modeling) that makes a kind of sense.<br>5. **Modeling** (2.4)<br>a. Multiple Models (2.4.2). You report that the multiple models perform significantly better than a consolidated model. You do not report the data in a way that allows the reader to conclude that you have proven this point (for example, Table 6 does not present the C statistic for a unitary model | | |

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| | nor is the specification of the unitary model clear). At a minimum, it would be helpful to describe illustrative differences between the models; ideally complete contrasts.<br>b. Cohorts (2.4.3). I think the logic of the split between cardiorespiratory and cardiovascular is not entirely clear, which may in part be a matter of language – the two words do not convey a clear distinction. I suspect it is really about procedures.<br>6. **Risk Adjustment** (2.5). In the introduction you make the following potentially explosive statement, "Consistent with NQF guidelines, we did not adjust for socioeconomic status, gender, race, or ethnicity because hospitals should not be held to different standards of care based on the demographics of their patients." To give one example of application, this ideological statement means that hospitals with large numbers of Medicaid patients would be expected to have the same readmission rates as those with none even though there is abundant evidence that Medicaid patients have higher readmission rates unless special and costly steps are taken to protect them. If these hospitals have higher readmission rates then, under ACA section 3025, their Medicare payments will be reduced. There is no option in the law to somehow compensate for the reduction because the needs of Medicaid patients make preventing readmissions more costly.<br>a. Models (2.5.1). This section starts with the very important statement that the goal is to account for differences across hospitals that are unrelated to quality of care. I am therefore disappointed and concerned that<br>1) The models are apparently not tested for their impact on hospital reporting or ranking. The critical test of an adjustment system is whether it makes the hospital O/E ratios more accurate, and a significant simple test is whether an added adjustment changes those O/E ratios compared to the ratios without that adjustment. Put differently, the C statistic has little policy value – what has policy value is adjustments that appear valid and change hospital performance as measured by the O/E ratio or an equivalent test.<br>2) You do not further examine the phrase "differences across hospitals that are unrelated to quality of care." A key issue is that hospital case mix (in terms of risk of readmission) is not unrelated to quality of care (as proxied by the readmission rate). If a hospital has a higher than expected rate of readmissions then it is almost certain to wind up with a risk profile dominated by conditions associated with frequent readmissions and vice versa. Any reasonable approach that seeks to identify "differences across hospitals that are unrelated to quality of care" must take some approach to separating differences that are the result of unexpectedly high (or low) readmission rates from differences that are unrelated to quality of care.<br>3) Dynamic modeling. A closely-related issue is that the measure you develop is intended to be used in a dynamic setting – that is, one where readmission rates change because of hospital efforts to respond to the incentives created by a payment system based on the measure. For a variety of reasons, including that interventions reduce readmissions well beyond 30 days, the denominator of the rate changes more (as a percentage of baseline) than the numerator, leading to quite unpredictable changes in the rate as the number of readmissions decreases (improves). Your discussion really needs to deal with this issue; there is little reason to believe that risk adjustment will take care of this problem.<br>b. Risk variables (2.5.2). The process for selecting variables is sensible and thorough, but it is very short on rigorous specification, and it seems very likely that separate system builders using these procedures would not arrive at the same results. There is no sign that reliability is addressed, but it is a known problem from 3M's work and cannot be ignored. We have, for example, known for two decades that myocardial infarction patients with elevated blood pressure on admission had better survival than others; while this may not yet be understood, it should not be dismissed as | | |

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| | implausible.<br>c. Service mix adjustment (2.5.3). The argument here is difficult to follow. How do you tell if the service mix is sufficiently "similar" and what do you do besides the condition category indicator variables? And what is the ground for the 1000 admission cutoff for using such indicator variables? While that is a pretty modest requirement you might want to a) explain where the number came from, b) discuss the total number of index admissions that have no indicator variable, and c) examine whether they concentrate in certain hospitals (as chemotherapy does) so that it matters even if the numbers are small.<br>7. **Statistical approach** (2.6)<br>a. Models for each cohort of conditions (2.6.1). This section is an exception to the general lucidity of the paper. One problem is that there are many symbols that are not defined, including A, k, N(0,t2),ωj. A second problem is that some of the ideas seem to assume a level of knowledge that I do not have or to be unclearly expressed. For example, the risk-adjusted readmission ratio is predicted/expected, much like the familiar O/E ratio, but this seems to be calculated in a somewhat roundabout way. I suggest having this entire section edited by a smart non-statistician.<br>b. Hospital performance reporting. It is not clear why the hospital performance figure is calculated as the geometric rather than the arithmetic mean. What are the policy implications of this choice?<br>c. The policy implications of selecting 95% CIs deserve careful discussion. On the one hand there is an implication that 5% (if the population is 4500 hospitals then 225) of hospitals will lie outside that interval by chance along. If 7 cohorts are used the number rises sharply. How might this problem be addressed? For example, could we look at stability over several years of data? Whatever the best solution, the question really needs discussion. | | |
| 8/29/2011 | Section 3025 of Public Law 111-148, the Patient Protection and Affordable Care Act (hereafter PPACA) establishes substantial penalties for hospitals that continue to have high short-term readmission rates. In order to implement this provision, Centers for Medicare & Medicaid Services (CMS) needs to have a method to calculate readmission rates that can be calculated much more promptly than the 3-year dataset required for the current Hospital Compare readmission metrics, that is reasonably risk-adjusted, and that adequately reflects quality of care. Dr. Steve Jencks has reviewed and submitted the various technical concerns and I encourage the working team to respond to those. Nevertheless, the proposed method is a reasonable effort to accomplish the statutory aim, and it should go forward for the proposed testing and, unless there are unanticipated and irremediable problems, should then be the anchor of the penalties in Section 3025 of PPACA. The fact that this method will entail substantial technical shortcomings and will be different from the method used to guide improvement activities in the Community-Based Care Transitions Program (Section 3026 of PPACA), the Quality Improvement Organizations (QIO) work, the Partnership for Patients, and various private measurement strategies will be confusing, but the effects seem to be tolerable for the next few years, mainly because the health care system's performance on care transitions is sufficiently poor that quite imperfect measures will be adequate to indicate improvement.<br><br>However, CMS should immediately address certain problems that are very likely to undercut the<br>usefulness of this and any other rehospitalization rate within a few years and specifically should build the measures that can measure quality across settings directly and to estimate aggregate costs of care, because those endeavors are what we will need when rehospitalization rates become inadequate indicators. | Joanne Lynn, MD, MA, MS, Director, Center for Elder Care and Advanced Illness, Altarum Institute | Hospital/ health system |

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| | The data that establishes that rehospitalization rates indicate poor quality is reasonably convincing only in the context of truly severe system dysfunction. Multiple studies and anecdotal reports have tallied over 90% error rates in such critical care transitions processes as information transfer and medication reconciliation. In the current situation, even slightly better performance can be tracked with very insensitive and indirect measures. An analogy might be that one does not need elegant measurement to detect the difference between hot and cold drinks. If all other drinks are hot, even a lukewarm one is detectable to the unaided hand. Likewise, if the usual hospital discharge has high risks of serious errors, and some proportion of those cause the patient to return quickly, then reducing the risks of serious discharge errors probably roughly correlates with improving the rate of rehospitalization. And that is all that the few studies of the correlation have shown. Most policy steps that have encouraged reduction in rehospitalization rates have relied upon variation across geographic areas and have been fueled by policymakers being surprised that one-fifth of Medicare beneficiaries discharged from hospitals were returning within 30 days. Since some areas had lower rates and this rate seemed patently high, policy has converged on improving care transitions and thereby reducing rehospitalization rates.<br><br>However, if the situation actually improves with the advent of support for improvement activities coming from Section 3026 of PPACA, QIOs' 10th Statement of Work, Partnership for Patients, and efforts to integrate care (as in the Accountable Care Organization endeavor) -- and the serious penalties upcoming under Section 3025 of PPACA -- then the currently high rates of error will decline substantially. At that point, we simply do not know how rehospitalization rates will behave. Just as the hand may no longer be adequate to judge variations in temperature when the range is smaller, we may need much more well-calibrated measures when the context changes.<br><br>At least one strong reason substantiates a prediction that any rehospitalization rate will then be misleading, and that is the early evidence from the QIO work that improvements in care transitions and support of seriously chronically ill persons in the community ends up affecting the denominator substantially. Measuring progress by a rate in which improvement affects both numerator and denominator is a very unstable method that will yield unpredictable effects upon the apparent rate attributed to different providers or improvement strategies. Indeed, in a situation where the care system maximally supported very sick people in the community, it is plausible that the optimal rate of rehospitalization would go up rather than down, because the hospital population would be much smaller and biased toward people with very fragile health who also rely upon services available only in hospitals.<br><br>Other reasons to doubt the merit of the proposed rehospitalization rate now and over time include:<br>• Claims-based risk adjustment cannot include direct measures of severity of illness, functional disability, or conventionally under-coded diagnoses (such as mental illness);<br>• Claims-based risk adjustment cannot account for social and personal factors that may be unevenly distributed and that affect rehospitalization, such as domestic abuse and neglect, lack of appropriate housing or caregiving, inadequate access to medications or appropriate food, poverty, and strong-willed patients insisting upon taking risks;<br>• Claims-based risk adjustment cannot account for variations in goals of care among patients or in the ability of non-hospital community | | |

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| | supports to care for people with substantial illnesses;<br>• Claims-based risk adjustment cannot account for the effect of care that yields variations in duration of survival with serious illness; and<br>• This new and novel measure will go into production without formal testing of its correlation with "gold standards" as to better and worse care patterns.<br><br>Since the measure needed immediately will initially perform in the context of severely dysfunctional patterns of hospital discharges, the proposed measure is probably adequate, and its responsiveness to improvement or to variation could be tested before or during initial deployment. However, once nationwide care systems have responded with the first wave of improvement, a much more direct set of measures will be needed, and CMS (along with partners such as the Agency for Healthcare Research and Quality, the National Institute on Aging, the Office of the National Coordinator, and grant-making foundations) should move now to build the measures that will be needed which include:<br>1. Direct measures of the existence, adequacy (to include patient and family priorities as well as honest assessment of the medical and social situation), implementation, and continuity of personal care plans for persons living with serious chronic illness,<br>2. Direct measures of the continuity of various key elements of such care plans across transitions of care – medication, other treatment, diagnostic tests, patient and caregiver self-care support, standardization of the transition process in an area, feedback from downstream care settings to upstream ones, and<br>3. Practical measures of resource utilization from private and public sources, aiming to monitor true costs rather than focusing only on Medicare-paid hospital utilization.<br><br>Rehospitalization is a very indirect measure of quality. Certainly, some rehospitalization arises from inadequate services in the upstream provider, the downstream provider, or the transition, but some also arise from influences such as the availability of supportive services in the community, the attitudes and practices with regard to efforts to support people coming to the end of life, and the symbolism of hope and reliability that the community ascribes to its hospitals. In order to detect the predicted loss of utility of the indirect measure of quality provided by rehospitalization rates, and then to substitute better metrics, we need reliable and practical direct measures. Development of the measures will require at least a few years, since there are very few in development now. So, CMS should go ahead and implement this proposed measure, but CMS should also develop better measures that we will need soon. | | |
| 8/29/2011 | The Consumer-Purchaser Disclosure Project (CPDP) is an initiative that is improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and payment. We are a collaboration of over sixty leading national and local employer, consumer, and labor organizations. We appreciate the opportunity to comment on YNHHSC/CORE's measure of hospital-wide (all-condition) readmission.<br><br>We applaud CMS' efforts to develop an outcome measure in this critical area of patient care. The document importantly highlights the cost of readmissions to patients (i.e., stress, loss of functional ability, etc.). | Christine Chen<br>Policy Analyst<br>Consumer-Purchaser Disclosure Project | Advocacy organization |

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| | CPDP supports the agency's intention to test and adapt this measure for all-payer datasets. This will facilitate measure standardization across public and private sectors. Issues CMS will need to address include that the measure is currently specified to only cover patients that are 65 and older, because "younger Medicare patients represent a distinct population with dissimilar characteristics and outcomes." This limits the measure's applicability to the commercial population. But this challenge can be easily rectified by anyone who has access to a multi-payer claims database that includes commercial as well as Medicare data. We therefore recommend that CMS immediately expand the applicability of the measure to the under 65 population and, if the agency is interested in a specific age group, stratify by age or include age as a continuous variable in the risk-adjustment formula.<br><br>We appreciate the agency's commitment to developing the measure for public reporting. By publicly reporting hospital quality, CMS seeks to help consumers, purchasers, and others to make better decisions. However, for the information to be truly useful to these audiences, it must distinguish performance among providers. And as we have commented to CMS and YNHHSC/CORE in the past, HGLM can wash away nearly all of the variation observed in the raw data because of the way in which it shrinks performance data towards the mean. The result is that most providers (i.e., individual hospitals) being profiled will be labeled as "average." In the case of this measure, YNHHSC/CORE's choice of risk adjustment method reduced variation across hospitals from observed rates of appropriately 0%-30% to adjusted rates of approximately 15%-20% for readmissions. Regardless of which statistical test is used, the shrinkage in the distribution resulting from this HGLM will not allow for much differentiation of hospital performance, resulting in little or no information for consumers and purchasers (or for the hospitals themselves, for that matter).<br><br>In the document, YNHHSC/CORE states that its risk adjustment is consistent with NQF's recommendations for publicly-reported outcome measures (page 32). However the developer did not raise a higher order question of whether the measure will meet NQF's evaluation criterion of "usability." Usability is the "extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and find them useful for decision-making."<br><br>In our conversations with other statisticians, we have found that which risk adjustment method is used is a matter of philosophy as there is no consensus about which is the "best." As a result, we recommend that YNHHSC/CORE also apply more traditional logistic regression approaches to the readmission data and share the results with CMS so that the agency can decide which risk adjustment method is best suited to its goal of publicly reporting how well hospitals care for their patients. If the inclusion of small hospitals is an issue, another possible solution to investigate would be to segment the hospitals into groups representing small, medium, and large hospitals and then apply the HGLM separately to each group.<br><br>On behalf of consumers and purchasers across the country, thank you for your consideration of our comments. If you have any questions, please don't hesitate to contact David Hopkins [redacted], who is a team member of CPDP. | | |
| 8/29/2011 | On behalf of Partners HealthCare and its acute member hospitals, we appreciate the opportunity to offer comments on the proposed methodology for a Hospital-Wide, all condition, 30-day risk-standardized readmission measure.<br><br>Partners' appreciates the value of thoughtfully constructed performance measures for bringing about improved quality in patient care and | Sheridan L. Kassirer<br>Vice President, Quality Management and Clinical | Hospital/ health system |

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| | acknowledges the considerable effort that went into creating this measure. In general, as Partners has shared in prior readmission comment letters, we emphasize our concern to CMS over the ability to identify planned readmissions from administrative databases. Such datasets exclude clinical information that can more accurately and comprehensively adjust for differences in severity. In addition to this overarching comment, we suggest the following for improving the accuracy of the measure and its acceptance by the medical community.<br>**Inclusion and Exclusion Criteria**<br>**Transplants and Devices**<br>Partners strongly urges CMS to exclude patients who have undergone bone marrow or other organ transplants from this measure. This unique population of immunosuppressed patients frequently utilizes inpatient care and is concentrated in a small number of teaching hospitals.<br>Given that existing risk adjustment methodologies cannot reliably adjust for the severity of illness in such patients, including them in a hospital-wide readmission measure will unfairly favor hospitals that do not usually care for transplant recipients. We do not believe that including covariates designating transplant status in regression models is sufficient to adjust for this stark difference between the small number of teaching hospitals caring for the majority of transplant recipients and all remaining US hospitals. Similarly, we recommend excluding patients with left ventricular (cardiac) assist devices and cystic fibrosis, from this readmission measure, for reasons cited above.<br>**Transfer Patients**<br>Partners recommends that transfer patients be excluded from this measure. Although the Yale<br>New Haven Health Services Corporation/Center for Outcomes Research and Evaluation<br>(YNHHSC/CORE) team has included a condition-specific indicator (AHRQ CCS) in their regression models, this is insufficient to adjust for the higher severity of illness of patients transferred to teaching hospitals after all therapeutic options have been exhausted in the community hospital setting. Excluding transferred patients from this measure is the only reliable way to keep from unfairly favoring community hospitals over teaching hospitals.<br>**Non-compliant Patients**<br>Some patients will continue to be readmitted multiple times due to non-compliance with medical advice or medical therapy. CMS can avoid penalizing hospitals for patients' noncompliance by excluding patients with documentation of non-compliance in the medical record, ICD-9 code V15.81.<br>**Organization into Cohorts of Conditions**<br>Partners recommends that YNHHSC reclassify the following condition categories from medicine to the surgical/gynecological cohort : 136 disorders of teeth and jaw, 142 appendicitis and<br>other appendiceal conditions, 143 abdominal hernia, 162 other diseases of bladder and urethra, 164 hyperplasia of prostate, 169 endometriosis, 170 prolapse of female genital organs, 174 female infertility, 225 joint disorders and dislocations/trauma-related, 228 skull and face fractures, 230 fracture of lower limb, 231 other fractures, 235 open wounds of head/neck/trunk, 236 open wounds of extremities, 240 burns, and 244 other injuries and conditions due to external causes. Further, if condition category 56, cystic fibrosis, is not to be excluded from the measure as we recommended above, then consider reclassifying it under the cardiorespiratory cohort instead of general medicine. | Programs<br>Partners HealthCare System, Inc. | |

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| | **Definition of Planned Readmissions**<br>Partners has serious reservations about the proposed methodology for defining planned readmissions. Although the two main principles that underpin the selection algorithm seem reasonable, narrowing the list of procedures from AHRQ's 231 categories down to only 32 "typically planned procedures" seems like an oversimplification. Several procedures that could potentially be planned are excluded from this list, for example: 2 insertion/replacement or removal of extracranial ventricular shunt, 72 colostomy temporary/permanent, 73 ileostomy and other enterostomy, 75 small bowel resection, 87 laparoscopy (GI only), 89 exploratory laparotomy, 90 excision/lysis peritoneal adhesions, 101 transurethral excision/drainage or removal urinary obstruction, 127 dilatation and curettage or aspiration after delivery or abortion, 169 debridement of wound/infection/burn, and 222 blood transfusion.<br><br>Partners recommends excluding the following condition categories from the list of 26 discharge conditions categorized under "acute or complications of care": 237 complication of device, 105 conduction disorders, 106 cardiac dysrhythmias, and 160 calculus of urinary tract. Readmission for complication of a device should exclude complication due to device failure. Further, it is possible for a patient to have a planned readmission for insertion/revision/replacement/removal of cardiac pacemaker or cardioverter/defibrillator (procedure category 48) under condition category 105 or 106 and applying this exclusion in the selection algorithm may erroneously classify such a readmission as unplanned. Similarly, it is possible for a patient to have a planned readmission for transurethral excision/drainage or removal urinary obstruction (procedure category 101, as discussed above) and be misclassified as unplanned if the condition category 160 exclusion is applied.<br><br>Finally, as Partners has suggested in prior comment letters, we recommend CMS consider a readmissions measurement methodology that compares a hospital to its own performance, and reward for improvement, to avoid attempts to game scoring through coding.<br><br>Thank you for the opportunity to offer comments on the proposed hospital wide readmission measure methodology. As CMS considers this measure for inclusion in its Inpatient Quality Reporting Program, Hospital Value-Based Purchasing Program, and Readmission Reduction Program, for example, Partners requests that CMS assess and share an impact analysis of the effects of a single measure included among several programs to ensure that excessive penalties do not become part of policy. If you have any questions regarding our comments, please contact Diane O'Connor, Project Manager[redacted]. | | |
| 8/29/2011 | The American Association of Orthopaedic Surgeons (AAOS) appreciates the opportunity to comment on the "Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure" (HWR) Draft Measure Methodology Report submitted by Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (YNHHSC/CORE). The AAOS represents over 18,000 board-certified orthopaedic surgeons and has been a committed partner with the Centers for Medicare and Medicaid Services (CMS) in patient safety and quality health care.<br><br>The AAOS looks forward to continued partnerships with both CMS and Yale for any and all musculoskeletal, surgery, or specialty quality and patient safety initiatives. The AAOS is dedicated to committing considerable human and financial resources to developing and analyzing evidencebased process and outcome measures and encouraging the adoption of evidence-based practice guidelines for the prevention, diagnosis, and management | Daniel J. Berry, MD<br>President<br>American Association of Orthopaedic Surgeons | Medical Professional Association |

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| | of musculoskeletal disease. We invite CMS and Yale to call on us as a partner and expert in performance and quality measurement in musculoskeletal care.<br>**General Comments**<br>The AAOS commends CMS and Yale on the immense progress made in developing these methodologies and drafting the report, which presents a measure for 30-day readmission following hospitalization for any condition that is based on administrative claims data for fee-for-service Medicare beneficiaries 65 years and older. As a general comment, the AAOS supports quality measures that are actionable and help align and coordinate care in all settings by all providers. We support the measurement and reduction of complications and readmissions. We have concerns, however, with the ability of the overall performance rate to inform a hospital of its specific needs for quality and patient safety improvement. The AAOS is concerned that while the measure would employ multiple assessment models, which may increase the likelihood of providing actionable information to hospitals, the broad cohorts used would limit whatever utility is provided by those models.<br>**Planned Readmissions**<br>The AAOS believes that separating readmissions into "planned" readmissions and "unplanned" readmissions is a step in the right direction. To our knowledge, this is the first time there has been recognition that certain readmissions may be planned. The AAOS recommends, however, that the concept should be integrated into existing readmission measures. We also recommend that CMS and Yale focus on condition-specific readmissions as a better approach to providing valuable feedback to hospitals and improving health care quality.<br><br>The AAOS acknowledges that defining the outcome as "all-cause unplanned readmissions" rather than "readmissions related to the previous hospitalization" alleviates some attribution issues such as determining whether a readmission is related to the previous hospitalization based on the documented cause of readmission. Yet, accurate attribution should be a critical element of all performance assessment and quality improvement initiatives. Moreover, there is a need to further delineate what the goal of the measure is. With an elderly, frail patient, readmission may not be a bad outcome or an inappropriate use of health care resources. In assessing a hospital's performance, CMS must be cognizant of the potential to mischaracterize the "appropriateness" of hospital admissions or readmissions under the proposed methodology. The AAOS is also concerned that the definitions and methodologies presented may characterize some readmissions, particularly those for chronically ill patients, as "unplanned" when they are in fact "planned."<br>**Risk-Adjustment/Choice of Covariates**<br>The AAOS appreciates the extensive work done to ensure a robust risk-adjustment model for the HWR quality measure. The AAOS commends Yale in adopting a multi-level approach to risk adjustment, including its use of hierarchical generalized linear models (HGLMs) to adjust for differences in hospital case mix and to account for the clustering of patients within a hospital, its regression analyses, its attempt to adjust for case mix differences among hospitals by riskadjusting for patients' co-morbid conditions, and its risk-adjustment for service mix differences among hospitals.<br><br>The AAOS supports movement toward developing clinically relevant quality measures which recognize the importance of measuring both process and outcome. We cannot stress enough the importance of risk adjustment when outcome measures are publicly reported and/or used in future | | |

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| | value-based purchasing programs. These quality tools rely on accurate, valid, and reliable data to inform stakeholders and improve quality. Risk adjustment facilitates equitable comparison among providers by accounting for patients' co-morbidities and co-conditions that increase their risk for complications and further treatment. Risk adjustment will significantly vary for acute and chronic conditions and among the individual conditions or procedures. The AAOS urges CMS and Yale to proceed cautiously to ensure accuracy and reliability of the proposed methodologies as well as the quality of data. The AAOS also believes administrative claims may not give the information that is needed to fully and accurately assess hospitals' performance or to properly characterize readmissions.<br><br>The AAOS recommends that CMS capture as many co-morbidities as possible in its risk adjustment methodologies. Each condition and/or procedure has different associated comorbidities, co-conditions, and complications. Chronic conditions have associated acute episodes that may be unavoidable and other associated acute episodes that are avoidable. In addition, chronic conditions will have acute episodes that are unrelated to that condition. Accordingly, post-acute care and readmissions will vary in their necessity and preventability based on each specific condition and/or procedure and each patient's severity, co-morbidities, and treatment plans. The AAOS believes that risk adjustment must adequately account for each patient's unique risk factors.<br><br>Although accountability is for now at the hospital level, the AAOS believes there is simultaneously a need for a measure of admission/readmission for other settings of care to get a better picture of where people are coming from. Ultimately, it will be necessary to align quality reporting measures across all settings of care. This is a complicated task and the AAOS asks that CMS take a cautious approach and start by focusing on readmissions that can be adequately measured, have evidence-based guidelines, and are able to be accurately risk-adjusted.<br><br>Moreover, the AAOS believes the HWR measure places some high-risk and co-morbid patients at a disadvantage for access to quality care. We are concerned that hospitals will incentivize physicians to deselect patients based on their risk factors or co-morbidities. We hope CMS will consider this unintended consequence and focus on implementing more nuanced risk adjustment into the policy especially with such a diverse and complex Medicare population. If patient deselecting occurs, tertiary centers will be further inundated with the most complex, high-risk patients. The AAOS commends CMS and Yale for addressing risk adjustment in its measure, but urges CMS to further develop a means for risk adjusting for the wide range of variation in patient characteristics prior to fully implementing the policy. CMS should take into account the condition-specific or procedure-specific risk. We also believe that CMS should account for the patient-specific risk factors that affect preventability, even though it may be potentially more difficult to implement.<br><br>The AAOS agrees that hospitals in collaboration with medical communities can take actions to improve health care delivery and reduce readmissions by ensuring that patients are clinically ready at discharge, reducing the risk of infection, reconciling medications, and improving communications among providers involved in transition of care . The AAOS recognizes, however that there are many factors beyond the hospitals' control that may impact rates of readmission, including the patient's own behavior. We are committed to patient-centered care, yet we are concerned that our current health care system has a minimal culture of patient accountability. Before proceeding with implementation of readmission measures, CMS should consider the resources, structure, and cultural changes necessary to reasonably implement a meaningful policy. | | |

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| | **Surgery/Gynecology Cohort**<br>The AAOS appreciates Yale's methodology in structuring multiple models for seven different cohorts/groups of discharge condition categories or procedure categories, including general medicine, surgery/gyenecology, respiratory, cardiovascular, neurology, oncology, and psychiatry. The surgery/gynecology cohort includes hospital admissions likely cared for by surgical or gynecologic teams, and it uses the Agency for Healthcare Research and Quality (AHRQ) procedure categories to identify these patients. The AAOS is concerned that the breadth of this large cohort and the numerous procedures encompassed within it will limit the utility of the data collected. Therefore, we recommend further sub-dividing this cohort of patients into clinically relevant cohorts of elective and non-elective surgical patients.<br><br>The AAOS appreciates this opportunity to provide input on an the all-condition, 30-day readmission measure developed for potential use in public reporting. We look forward to working with CMS and Yale on future musculoskeletal, surgical and specialty issues. Please contact William R. Martin, III, MD, at [redacted] with any questions about the AAOS comments. | | |
| 8/29/2011 | The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the draft hospital-wide 30-day risk-standardized readmission measure. NAPH members are highly committed to reducing inappropriate readmissions. In a recent survey, 86% of NAPH members indicated that they had established readmissions as a top priority for their hospitals. NAPH would like to thank the Centers for Medicare & Medicaid Services (CMS) for taking past stakeholder input into account when preparing this draft measure. In particular, we very much appreciate CMS' efforts to exclude several categories of planned readmissions and to expand the list of condition-specific exclusions. The following comments reflect three issues of concern to safety net hospitals.<br>**Risk Adjustment**<br>While we appreciate that the draft readmission measure is adjusted for differences in patient case mix and mix of services, NAPH believes that CMS should not rely on past National Quality Forum (NQF) principles to justify its decision not to risk-adjust for demographic or socioeconomic factors. NQF has recently moved away from its aspirational principle of excluding race and socioeconomic status from risk-adjustment. In its report entitled, *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*, NQF acknowledged that there is a need to develop measures that "address diverse populations." In addition, a comprehensive literature review has shown that socioeconomic factors can have a significant impact on health outcomes, including on readmissions. For example, a recent peer-reviewed study found that African Americans and low-income patients who are dually-eligible for Medicare and Medicaid may be more likely to be readmitted.<br><br>**NAPH recommends that CMS consider for inclusion in risk-adjustment methodologies both demographic and socioeconomic factors, including age, sex, race, ethnicity, primary language, income, education, health literacy, insurance status (including measures of underinsurance), disease and functional status (including comorbidities), post-discharge care-support structure, and access to primary care.** Appropriate risk-adjustment is critical to ensuring that readmission measures represent real differences in quality and care coordination, rather than unfairly penalizing certain hospitals for factors beyond their control. For example, two NAPH member hospitals recently studied unplanned readmissions to their hospitals and discovered that the primary driver of readmissions was patients' inability to provide a home phone number to hospital staff. Another member | Kevin J. Van Dyke, MPP<br>Policy Manager<br>National Association of Public Hospitals and Health Systems | Healthcare association |

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| | hospital also recently discovered that the only significant predictor for readmissions at its facility was homelessness. In addition, in a recent NAPH survey, half of our members who stratified their readmission data by socioeconomic factors found disparities by level of health literacy and for patients who lacked access to primary care follow-up in their neighborhoods.<br>**Exclusions**<br>While we are pleased that CMS has included additional exclusions in the draft measure, NAPH believes that more exclusion criteria are needed to accurately gauge hospitals' readmission performance. Many health care policy experts, including the Medicare Payment Advisory Commission (MedPAC) and the Congressional Research Service, have recognized that broader exclusions for unrelated admissions are appropriate and necessary to ensure that hospitals are not penalized for medically appropriate readmissions. For example, a 3M analysis conducted for MedPAC found that excluding readmissions related to trauma, cancer, and burns, and excluding most surgical readmissions following an initial medical or surgical admission, more accurately identified readmissions that were related to the original admission and potentially preventable.<br>**Therefore, NAPH recommends that CMS consider broader exclusions.** There are additional types of admissions that, because of their characteristics, should be excluded from a readmissions measure. Specifically, admissions that are part of the natural disease or treatment progression and admissions that are mostly influenced by non-hospital community factors, such as patients' characteristics and home environments, should be excluded. For example, while not comprehensive, the following list details additional types of admissions that are not suitable for public reporting of hospital readmissions.<br>• **Natural Disease or Treatment Progression Admissions**<br>  • **Trauma**<br>  • **Burns**<br>  • **ESRD**<br>• **Community Factor-Related Admissions**<br>  • **Psychoses and mental health diagnoses**<br>  • **Substance abuse**<br>**Readmission Time Period**<br>NAPH believes that CMS should not limit itself to developing measures for 30-day readmissions. There is currently no clear consensus in the scientific literature that a 30-day readmission measure is more appropriate than a readmission measure that covers a shorter period of time. For example, many NAPH member hospitals track readmissions within a 7-day window and believe this measure to be more reflective of hospital-dependent readmission factors. The further in time that the readmission window expands from the original admission, the more dependent the measure is on patient and community factors of readmission, which are not appropriate for measures of hospital accountability. In addition, there are currently important national research studies being conducted on the appropriateness of a 15-day readmission measure. **NAPH recommends that CMS develop measures for 7, 15, AND 30-day readmissions until further research conclusively determines a time frame that is the most appropriate for hospital accountability.** | | |

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| 8/29/2011 | Overall this measure appears reasonably rational in its design (typical of the YALE group). There are many small decisions that could be questioned on defining the cohort, picking risk adjusters, etc, etc. Nonetheless, each of those individual decisions was made for some explainable reason. None of these decisions is perfect, but at least each one is done for some describable reason that is probably as good as any alternate decision. Reliance on administrative data has disadvantages which are well known and could affect the ultimate utility and acceptance of this measure, but many steps have been taken with this measure to optimize the treatment of the administrative data.<br><br>Regarding risk adjustment, again the approach presents defendable decisions, despite relying on administrative data. One concern is that while CMS or NQF might advise that performance not be adjusted for race, ethnicity, or socioeconomic status or factors, most practitioners in this discipline might agree that this still potentially penalizes institutions caring for certain disadvantaged populations via public reporting or incentive programs. This dilemma probably has to be resolved at a strategy level higher than Yale.<br><br>We would like to voice two major concerns.<br>1. The impact of this measure will likely be HUGE. Of course we do not yet know what financial incentives will ultimately be attached, but it is hard to imagine a hospital that will not be substantially affected by this measure. In short, about 88% of any hospital admission within 30 d of a prior admission are considered “unplanned” under this algorithm. Any performance issue that might be surfacing for institutions under the 3 existing readmission measures now will likely be tremendously magnified by this methodological approach, which attempts to address such broad areas (seven of them) that the possibility of false or confounded judgments seems exacerbated. This measure is clearly an amalgam of seven more focused models, but the judgments derived are then weighted and combined broadly. In addition, each of the seven sub-models itself is quite broad. For instance, we know in surgery that focusing performance models is generally desired, but this “Surgery/Gynecology” sub-model is actually incredibly broad- potentially more broad than any other existing performance model currently addressed to the surgical profession. The potential for confounding and bias even within each sub-model seems large. From these perspectives, these individual models and the aggregate measure seem very untested and unproven in terms of whether they hold validity for the real world of patient care, particularly given the likely magnitude of the impact of the measure.<br>2. The major concern about the model is not the risk-adjustment (which, based on 12 months of prior administrative data, will always be susceptible to certain types of error)- NO- the main concern with this measure is determining what is “planned” vs. “unplanned”. The approach relies on determining categories of diagnosis codes that are always planned (e.g.- maintenance chemotherapy), and categories of procedure codes that are likely planned unless accompanied by certain other codes indicating an acute event (e.g.- coronary stent with a diagnosis of atherosclerotic disease is considered planned, coronary stent with a diagnosis of MI is considered unplanned). Again, the approach is “explainable”, but totally unproven in terms of the impact in the real world. It is also not clear what level of specific expertise has been incorporated into making all these decisions- for instance for the vascular surgery readmission measure also developed by Yale for CMS, the team included surgeons and vascular surgeons (and representatives from the Society of Vascular Surgeons) - but in the current measure the category called Surgery/Gynecology is incredibly broad and within that category the specialty expertise applied to this development seems extremely limited. A broad measure such as this | Bruce Hall, MD, PhD, MBA, FACS<br>Barnes Jewish Corporation (BJC) Healthcare<br>Washington University in St Louis<br>American College of Surgeons | Individual |

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| | must incorporate specialty expertise at every level and for every involved discipline, especially regarding the “planned” vs. “unplanned” designation. This aspect of the measure approach (planned/unplanned) seems to be what will attract the most attention and criticism, and is probably the aspect for which most institutions will have difficulty gauging impact. | | |
| 8/29/2011 | Thank you for the opportunity to provide comments on the proposed 30 day all cause readmission rate metric. The Society of Hospital Medicine has had a long standing focus on improving care transitions across inpatient and outpatient care settings which has a major impact on re-hospitalizations. SHM welcomes the addition of goals and metrics that elevate the visibility of this work.<br><br>The proposed metric of an all cause 30-day readmission rate is a more inclusive measure than methodologies that try to calculate potentially preventable readmission rates via DRG-like groups or cumbersome chart abstraction. The 30-day all cause readmission metric is also less susceptible to altered coding practices as a strategy to improve performance. For these reasons SHM would support this all-cause 30 day readmission metric strategy.<br><br>The inclusion and exclusion criteria as written are comprehensive. The methodology to exclude readmissions to alternate acute care settings may need to be strengthened to ensure that planned re-hospitalizations that are often viewed as transfers are truly excluded. These readmissions include planned transfers to inpatient mental health and chemical dependency units, inpatient rehabilitation units, and LTACs (long term acute care hospitals). A rationale for the plan to exclude a subset of patients with ‘high competing mortality risk conditions’ would be needed before SHM would endorse this exclusion. Although inclusion of these patients in the cohort does have the potential to interfere with the readmission quality signal, it is these same diagnoses and individuals who present one of the highest readmission risk areas and one of the largest opportunities to intervene with options for palliative care and hospice care to provide a more patient centered experience and improved economic stewardship. Allocating performance into 7 disease specific cohort categories is an important contribution to the readmission metric methodology. The cohort divisions will help to direct future hospital process improvement efforts into service line operations and will also aid in the accuracy of the risk stratification process.<br><br>The list of excluded planned procedures is comprehensive, but should be subject to at least an annual review and edited to include additional or new procedures.<br>The risk adjustment methodology does not fully account for multiple factors that are potent drivers of readmission risk (homelessness, lack of primary care access, low health literacy, socioeconomic class, etc). Without this kind of risk adjustment, hospitals caring for large immigrant or uninsured populations are at a significant disadvantage. Major drivers for reducing unnecessary readmissions are timely outpatient follow-up and medicine compliance. Uninsured, economically disadvantaged patients who do not have easy access to outpatient care are at much higher risk for a readmission despite the best of inpatient care. We understand that hospitals should not be held to different standards based on demographics, but at a minimum, they should be tracked separately so performance could be measured in this distinct cohort. Additionally, consideration might be given to looking at hospice care as a distinct cohort with its own set of readmissions measures. | Wendy Nickel<br>Associate Vice President<br>Center for Hospital Innovation and Improvement<br>Society of Hospital Medicine | Healthcare association |

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| | Furthermore, since the aforementioned risk characteristics are not routinely captured in structured data fields in common administrative databases, efforts should be made to take them into consideration. As 'meaningful use' criteria for hospital EHR systems mature, these important drivers of readmission risk should be included in future versions of this risk adjustment methodology.<br>Thank you for the opportunity to provide comment on this important quality metric. Should you have any questions or concerns, please don't hesitate to contact me directly [redacted]. | | |
| 8/29/2011 | The Federation of American Hospitals (FAH) is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. On behalf of our member hospitals, we are pleased to offer the following comments on the "Hospital-wide (All-Condition) 30-Day Risk-Standardized Readmission Measure" currently in development under contract with CMS.<br><br>In general, the FAH appreciates that the measure developers explored in greater detail several variables of great importance to hospitals. For example, we were pleased to see the measure relies on one-year of data. Hospitals can more quickly react to data proximal to the actual index admission for a patient.<br>The FAH is pleased to see a robust section in the Draft Measure Methodology Report around identification of conditions for exclusion as planned readmissions. Ensuring appropriate exclusions for planned readmissions within 30 days is important not only to ensure fair assessment of the hospital, but also to avoid unintended consequences for patients. To that end, we strongly support the list of 32 planned procedures included in the report.<br><br>The FAH is intrigued by the exclusion methodology discussed in the report and appreciates the recognition that additional exclusions should be considered. In particular, the FAH is supportive of the rationale for excluding cancer patients for at least the medical and oncology cohort and would recommend that the measure developers consider including this exclusion for all condition cohorts. Oncology patients, no matter the admission cohort, have a higher likelihood of returning due to the complications associated with chemo-therapy treatment and the course of the disease.<br><br>We also would recommend that the measure developers and CMS consider certain other types of admissions that, because of their characteristics, should be excluded from any readmission measure. Specifically, we would support the exclusion of certain non-procedure planned admissions, admissions that are part of the natural disease or treatment progression, and admissions that are mostly influenced by non-hospital community factors, such as patients' characteristics and home environments.<br>While not exhaustive, the following list details certain types of admissions that we believe to be inappropriate for inclusion in a readmissions measure that could be adopted for public reporting and/or use in the Hospital Readmissions Reduction Program.<br>**Planned Admissions: (**Cancer; Maternity; Rehabilitation)<br>**Natural Disease or Treatment Progression Admissions: (**Congestive heart failure; Trauma; Burns; ESRD; Sepsis)<br>**Community Factor-Related Admissions: (**Psychoses and mental health diagnoses; Substance use) | Jayne Hart Chambers<br>Sr. V.P. Strategic Policy & Corporate Secretary<br>Federation of American Hospitals | Healthcare Association |

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| | The FAH is interested in learning more about the developers' reasoning for creating one measure with seven cohorts instead of seven individual measures. We are intrigued by the cohort methodology described in the report, and would encourage the developers to further elaborate on why a single measure is better than seven distinct measures or a measure that is stratified by the cohorts.<br>We do have serious concerns about several aspects of the proposed measure. The FAH continues to have concerns about the 30-day timeframe for any readmission measure and would ask CMS and the measure developers to strongly consider a 15-day timeframe instead, which we believe is far more appropriate for assessing hospital quality and performance. We strongly recommend that research be undertaken to assess the impact and appropriateness of other timeframes, such as 7, 14, and 21 days and that the results of such modeling be made available prior to finalizing this 30-day measure.<br>The FAH believes that clinically, a 15-day timeframe for measuring readmissions is more reflective of the quality of care a patient received during the index hospital stay. By measuring beyond 15 days, CMS is potentially holding hospitals accountable for a range of circumstances, including poor community infrastructure and natural progression of disease, which are not within the institution's control.<br><br>The FAH also would appreciate additional details on how this proposed measure would be harmonized with the current readmission measures for heart failure, AMI, and pneumonia, and other conditions or procedure-specific readmission measures under development. Without a clear and concrete process for harmonizing this measure, the potential exists for double counting of readmissions and a potential double penalty situation for hospitals should this measure be used for payment purposes.<br>The FAH also requests additional clarification of the application of this proposed measure to critical access hospitals (CAHs). It is unclear how hospital transfers are treated in the measure under development, and why CAHs are included in this measure and excluded from previous readmissions measure developed by Yale.<br><br>Finally, with regard to risk adjustment methodology for this measure, the question of adjustment for Socio-Economic Status (SES) has not been adequately addressed in our view. This is a topic of great debate within the health care community and has been for some time. We see the purpose of risk adjustment as a means of controlling for variables that are beyond the control of the hospital. While we recognize there is currently no standard, valid methodology for adjusting for SES, it is clearly a variable beyond the control of the hospital. Therefore, we believe there should be continued attention and analysis to determine whether there is a set of SES indicators that should be adjusted to capture certain characteristics, such as the patient's ability to comply with discharge/post-procedure instructions, or community infrastructure to support the patient after discharge, while balancing the critical need to avoid unintended consequences.<br><br>Again, we appreciate the opportunity to comment during the development process on this new hospital-wide all condition risk-standardized readmission measure and look forward to continuing to work with CMS and its contractors to develop additional outcomes measures that will drive meaningful improvements in hospital performance. If you have questions regarding our comments please do not hesitate to contact me or Samantha Burch of my staff [redacted]. | | |
| 8/29/2011 | On behalf of the Premier healthcare alliance serving more than 2,500 leading hospitals and health systems and 75,000-plus other healthcare sites, | Christine L. Van Dusen | Hospital/ |

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| | we appreciate the opportunity to comment on the measure currently in development, titled “Hospital-wide Readmission(RSRR). The documentation and report was prepared by the Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE). Premier, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our owner hospitals and health systems which, as service providers, have a vested interest in the development of quality measures by the Centers for Medicare & Medicaid Services’ (CMS) CMS is requesting stakeholder review and public comment of this measure. Additionally, CMS is specifically interested in receiving feedback for the areas of inclusion and exclusion criteria, definition of the cohort, definition of planned readmissions, risk adjustment and the final choice of covariates.<br>**General Comments**<br>This is a complex measure requiring a large data set that is not generally available to providers to replicate. Hospitals are challenged to use the generated predicted rates for quality improvement purposes given the measure does not identify specific re-admitted patients and will in all likelihood be provided only once a year. At minimum, if CMS is to use a measure that is not replicable by providers for pay-for reporting and payment penalties, CMS should provide such calculated results on a quarterly basis, rather than the annual posting currently used for the condition-specific measures, to provide hospitals more actionable data.<br>**Inclusion and Exclusion Criteria**<br>Premier appreciates that the HWR inclusion criteria is aligned with the existing publicly reported measures. We concur with the addition of the criterion for admission is not to a PPS-exempt cancer hospital. In reviewing the exclusion criteria, we agree with the additional exclusion criterion of admission for rehabilitation care, and high mortality risk.<br>**Outcome Definition**<br>Premier is generally supportive of the methodology to identify planned admissions by linking Principal Diagnosis with an identified list of procedures including chemotherapy maintenance. We are concerned that this methodology is not used by the existing publicly reported readmission measures for AMI, Heart Failure and Pneumonia.<br><br>In addition, we also urge CMS to exclude conditions that may result in readmissions that are not “preventable” including trauma, psychoses, substance use, maternity and neonatal, and end-stage renal disease. CMS should actively and quickly work with the National Uniform Billing Committee to enable CMS, and other payors, to track planned readmissions through claims and alter the measure specifications to exclude additional cases for which the hospital should not be held accountable in this measure<br>**Definition of the Cohort**<br>Premier agrees with the grouping of patients using the AHRQ Clinical Classification System (AHRQCCS). We are concerned with the impact of the upcoming implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) on the cohort definition. The specificity of ICD-10-CM codes may result in revisions to the currently defined cohort. Premier recommends modeling the cohort definition using the latest ICD-10-CM version. The results of this modeling will be beneficial to assess the impact of ICD-10-CM on these measures. | Senior Consultant<br>Clinical Standards and Quality<br>Premier, Inc. | health system |

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| | **Risk Adjustment**<br>The risk adjustment methodology is based on the current AMI, Heart Failure and Pneumonia 30 readmission measures with modification to incorporate the seven cohorts. As stated in previous readmission measure comments, we do not agree with the exclusion of the patients' admission source, discharge disposition, and socioeconomic status. We realize this policy is consistent with the NQF guidelines; however, we believe these are valid factors that may be outside the control of the hospital and should be considered even if they cannot be directly attributed to the patient.<br><br>Additionally, we have concerns with the ranges of the c-statistics being 0.604 to 0.676. There was little discussion regarding the results of the c-statistics except for the statement 'that c-statistics for performance for each model are consistent with other public report measures'. However, this measure will most certainly be used not only for the Medicare inpatient pay for reporting program, but also the Readmission Reduction Program. On Hospital Compare, CMS is able to account for the low c-statistic by grouping hospitals above, at or below average, but the way the readmissions penalty is structured will create differential payment regardless of whether the performance is statistically significant between providers. This will result in hospitals being unfairly penalized for variation that is not statistically distinguishable and performance that is no worse than others. CMS will need to further refine this measure to improve the c-statistic if it is to be used beyond internal hospital quality improvement and public transparency for payment policies.<br>**Final Choice of Covariates**<br>The final choice of covariates appear to be adequate for normal risk modeling circumstances; however, given the low c-statistic, it is clear that there are unobserved independent variables that are not captured in this risk model that result in its inability to predict readmissions with accuracy. As stated previously, we do feel that a greater number of socioeconomic status variables would help in this regard.<br>**Conclusion**<br>In closing, Premier appreciates the opportunity to provide comments. If you have any questions, please contact Christine Van Dusen [redacted]. | | |
| 8/29/2011 | Atlantic Health has three major concerns with the following quality measure specifications posted on the CMS Website:<br>**3. Hospital-Wide 30-Day All-Cause Unplanned Risk-Standardized Readmission Rate**<br>The Centers for Medicare & Medicaid Services (CMS) has contracted with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE) to develop a hospital-wide (all-condition) 30-day readmission measure. This measure is being developed using Medicare Part A (inpatient only) administrative claims data and is designed for potential use in public reporting.<br><br>While we believe that reducing unplanned hospitalizations and re-hospitalizations is an important goal of quality improvement, there are serious reasons to question whether such reductions are associated with improved healthcare outcomes.<br>We include the following diagrams obtained from a previous publication from these authors for Acute Myocardial Infarction and Heart Failure Readmissions, which suggest that higher readmission rates are associated with low mortality rates.<br>Second, an online article published on August 22, 2011 in the Canadian Medical Association Journal | Donald E. Casey Jr., MD, MPH, MBA, FACP, FAHA<br>Chief Medical Officer & Vice President of Quality<br>Chief Research Officer & Chief Academic Officer<br>Atlantic Health | Hospital/ health system |

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| | (see http://www.cmaj.ca/content/early/2011/08/22/cmaj.110400.full.pdf+html?sid=c7492502-4d88-47a3-8ea8-d89594220ba7)<br>contains the following conclusions:<br>**Urgent readmissions deemed potentially avoidable were relatively uncommon, comprising less than 20% of all urgent readmissions following hospital discharge. Hospital-specific proportions of patients who were readmitted were not related to proportions with a potentially avoidable readmission.**<br>We believe that an all cause readmission rate for all index hospitalizations needs further study and improved correlation with improved clinical outcomes, especially mortality and quality of life. CMS would be wise to first explain the discrepancies noted by the Yale researchers in the Circulation figures noted above and also cross validate any analysis solely based upon Medicare administrative datasets containing only the first nine to twelve ICD-9 codes listed in complete claims that may contain as many as 30-40 other diagnostic codes. Additionally, there are many conditions that are "Present on Admission" that should be evaluated and included in the detailed analytics, with cross validation using information from the entire episode of care occurring between hospitalizations (e.g. Hospital-Acquired Infections, etc.).<br><br>C-Statistics in the submodels found on page 31 of the background document found on the CMS Website of between 0.60-0.68 indicates poor association with meaningful clinical outcomes.<br>*For a clinical prediction rule, **it is generally considered that a C statistic of less than 0.6 has no clinical value, 0.6 to 0.7 has limited value, 0.7 to 0.8 has modest value, and greater than 0.8 has discrimination adequate for genuine clinical utility.** Of note, a risk score may have a statistically significant association with a clinical outcome, but the relationship may not discriminate enough to allow clinicians to accurately and reproducibly separate patients who will and will not have the outcome. Furthermore, the C statistic value almost always is higher when assessing predictive accuracy in the patient data set used to develop the model rather than independent sets of patients.*<br>Ohman EM, Granger CB, Harrington RA, Lee KL. Risk stratification and therapeutic decision making in acute coronary syndromes. JAMA. 2000 Aug 16;284(7):876-8.<br><br>Finally, in the most recently released Hospital Compare data, no significant changes were noted in the publicly reported 30-day all cause readmission rates for Acute Myocardial Infarction, Heart Failure and Pneumonia using methods similar to that proposed in this new readmission rate. This suggests that public reporting of these rates by CMS has had no demonstrable effect in improving outcomes. We are also concerned that payment policies similar to those described in the Final Rule for the IPPS in 2012 are poorly constructed and likely to result in significant misspecification bias leading to financial penalties for those hospitals with better clinical outcomes, especially 30-day mortality results.<br>We hope that others copied on this e-mail will also respond to CMS before the 11:59 PM Deadline tonight via hospitalwide@yale.edu | | |
| 8/29/2011 | The American Hospital Association (AHA), which represents more than 5,000 member hospitals, health systems and other health care organizations and over 42,000 individual members, appreciates the opportunity to comment on this draft measure. Providing feedback through several stages of the measurement development process is critical to producing the best possible product. Today we are taking the opportunity to comment in the early stages of development and we are committed to providing feedback through further testing and possible endorsement phases as well. We | Nancy Foster<br>Vice President, Quality and Patient Safety<br>American Hospital | Healthcare Association |

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| | thank Yale for making this opportunity available.<br>**POSTIVE STEPS FORWARD**<br>For some time, we have been urging CMS to work with Yale to incorporate changes into the heart failure (HF), acute myocardial infarction (AMI) and pneumonia (PN) readmission measures. The *Patient Protection and Affordable Care Act (ACA)* of 2010 requires CMS to ensure all readmission measures used to implement section 3025 recognize planned, unplanned, related and unrelated readmissions. CMS contends that the current specifications for these measures address this statutory requirement and it does not intend to pursue any further modifications to the measures. The AHA strongly disagrees with CMS and believes the agency has ignored Congress' intent that the measures be modified to explicitly exclude unrelated and planned readmissions.<br><br>Despite the impasse we are at regarding the HF, AMI and PN readmission measures, we recognize that Yale has attempted to be responsive to some of our concerns with its draft allcondition readmission measure. Our summary of the positive steps forward are included below and **we urge Yale to make these same modifications to the HF, AMI and PN readmission measures**.<br><br>Distinct cohorts of patients. Rather than merging each of the seven cohorts of patients that Yale has created into one all-condition composite readmission measure, **we recommend Yale explore using the seven cohorts as seven separate and distinct readmission measures**. Focusing on seven different readmission measures achieves the same intended purpose, to capture hospitalwide readmissions, while also educating hospitals in distinct clinical areas they can concentrate on to improve performance. We commend Yale for pursuing these seven cohorts of: (1) general medicine, (2) surgery/gynecology, (3) cardiorespiratory, (4) cardiovascular, (5) neurology, (6) oncology and (7) psychiatry, as they represent distinct clinical areas of related medical conditions. **Because Yale has used clinical and analytic judgment to separate these related conditions out into distinct categories, we recommend that Yale use these seven cohorts to define related and unrelated conditions for the HF, AMI and PN readmission measures**.<br><br>For example, Yale could define the readmissions in the cardiovascular cohort as readmissions related to heart failure. Further, Yale could define the readmissions in the six other cohorts as unrelated to heart failure.<br><br>Planned procedures. For the all-condition readmission measure, Yale intends to remove 32 planned procedure admissions from the calculation of the measure. We support removal of these planned procedures. **We urge Yale to make the full list of planned procedures, beyond the 32 selected procedures, that it considered for removal from the all-condition readmission measure**. In the all-condition readmission report Yale notes: In 2008, there were 181,203 planned readmissions, accounting for 12% of all readmissions. **There are a considerable number of planned readmissions and we urge Yale to also remove these 32 planned procedures from the HF, AMI and PN readmission measures.** Exclusions. In addition to addressing a series of cancer conditions that are excluded from the allcondition readmission measure, **we urge Yale to also exclude conditions that capture transplant, end-stage renal disease, burn, trauma, psychosis and substance abuse**. Like cancer, these conditions are also candidates for the analysis Yale did to determine “high competing mortality risk condition categories.” We recommend that Yale map the additional exclusions we list to the Agency for Healthcare Research and Quality’s Clinical Classifications Software (CCS) and apply those CCS categories as exclusions. Further, we urge | Association | |

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| | Yale to apply these CCS exclusions to the **HF, AMI and PN readmission measures.**<br><br>Years of data. **The all-condition readmission measure captures one calendar year of data and we urge Yale to also consider this time period for the HF, AMI and PN readmission measures**. The current rolling three years of data that are used to calculate the HF, AMI and PN readmission measures makes it difficult for hospitals to improve their readmission rates from year to year.<br><br>**ADDITIONAL CHANGES NEEDED**<br>Though Yale has addressed some of the concerns we have been expressing regarding its readmission measures, there are still several areas in which Yale has not made changes in this most recent all-condition readmission measure. As we have indicated previously, these changes must also be made to the HF, AMI and PN readmission measures.<br><br>Disparities. **We urge Yale to stratify all of its readmission measures in order to properly address disparities**. The existence of racial disparities in health and health care is well established. Similar racial disparities in the health and health care of Medicare beneficiaries, in particular, have also been documented. These disparities extend to readmission to hospitals. Just this year, the *Journal of the American Medical Association* (JAMA) published an article showing that blacks have a higher likelihood of being readmitted to the hospital than do whites. In addition, the JAMA article concluded that hospitals serving a disproportionately large number of minorities have higher readmission rates. Proper accounting for these racial disparities is crucial.<br><br>Yale states: Consistent with National Quality Forum (NQF) guidelines, we did not adjust for socioeconomic status, gender, race, or ethnicity because hospitals should not be held to different standards of care based on the demographics of their patients.<br><br>However, the NQF guidelines are very clear in addressing disparities. The NQF's consensus development process calls for the following: If disparities in care have been identified, measure specifications, scoring and analysis allow for identification of disparities through stratification of results (e.g. by race, ethnicity, socioeconomic status, gender); or rationale/data justifies why stratification is not necessary or not feasible.<br><br>Risk adjustment. **We urge Yale to stratify all of its readmission measures in order to properly risk adjust each measure**. The risk-adjustment methodology included in Yale's readmission measures considers patients' diagnostic data (e.g., the severity of underlying medical conditions and co-morbidities) and demographic characteristics (e.g., age and gender). But, it does not consider a patients' race or life circumstances, which can have just as great an impact on health outcomes. The risk-adjustment methodology must include recognition, which may be done by stratification, of such patient characteristics as race and limited English proficiency. The NQF guidelines are very clear in addressing risk adjustment. The NQF's consensus development process calls for the following: It is preferable to stratify measures by race and socioeconomic status rather than adjusting out differences.<br>Post-discharge period. **We urge Yale to re-examine the proper post-discharge period that should be used for readmission measures**. We urge Yale to publicly release the data analysis it has conducted in order to empirically derive a 30-day post-discharge period for any of the existing readmission measures. | | |

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| | **OUTSTANDING QUESTIONS**<br>We thank Yale for giving the public the opportunity to weigh-in through the early stages of development on the all-condition readmission measure. However, in absence of reviewing the final measure specifications, we are left with several unanswered questions.<br><br>Measure harmonization. **How will the all-condition readmission measure be harmonized with the existing Yale readmissions measures in order to ensure there is not duplicate counting of readmissions?** We are concerned, since the all-condition readmission report did not reference exclusion of HF, AMI and PN admissions, that there will be double counting of readmissions. We urge Yale to ensure there is no double counting.<br><br>Critical access hospitals (CAHs). Why is critical access hospitals included in the all-condition measure? To the best of our knowledge, CAHs were not included in the HF, AMI and PN readmission measures. We urge Yale to articulate how transfers from CAHs to inpatient prospective payment system hospitals are handled in all of Yale's readmission measures. If you have any questions regarding these comments, please contact me [redacted] or Lisa Grabert, senior associate director for policy [redacted]. | | |
| 8/29/2011 | I would strongly support further study before any further data is released or acted on regarding readmissions and using this metric as a reflection of quality. | Frank W. Smart, MD, FACC, FACP<br>Professor and Chief<br>Section of Cardiology<br>Department of Medicine<br>LSU Health Science Center | Hospital/ health system |
| 8/29/2011 | On behalf of Providence Health & Services, thank you for the invitation to provide comment on the Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Rate Draft Measure Methodology Report. Providence Health & Services (Providence) is a faith-based, non-profit health system that includes 27 hospitals, more than 34 non-acute facilities, physician clinics, a health plan, a liberal arts university, a high school, approximately 50,000 employees, and numerous other health, housing, and educational services in Alaska, Washington, Montana, Oregon and California.<br><br>Providence is committed to excellence and high quality, compassionate health care. In order to truly improve quality and make health care more affordable, we understand providers must change the way they deliver care. A particularly important aspect of care, transitions across inpatient and outpatient settings, is addressed is this proposed Hospital-Wide 30-Day All-Cause Unplanned Risk-Standardized Readmission Rate measure and we appreciate this opportunity to provide comment. In this letter we address the proposed inclusion/exclusion criteria, cohort classification, planned readmissions, and risk adjustment model.<br><br>***Inclusion/exclusion criteria***<br>Providence is in general support of the inclusion/exclusion criteria in the draft methodology report, with recommendation for additions to exclusion criteria and further clarification. | Myron Berdischewsky, MD<br>Senior Vice President, Chief Medical and Quality Officer (CM&QO)<br>Providence Health and Services | Hospital/ health system |

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| | Additional exclusions:<br>• Same day readmissions are currently excluded from the CMS AMI publically reported measure and therefore should also be excluded from this measure.<br>• Psychiatric and chemical dependency patients should be excluded.<br>• Trauma and ESRD should be excluded.<br>• Maternity and neonatal diagnoses should be excluded if this measure crosses over to the Medicaid populations.<br>• Discharge disposition, "Patient Still Inpatient" should be excluded.<br>Further clarification recommended:<br>• Excluding patients with high post-hospital mortality risk may reduce the "noise" in the measurement; at the same time, it is these same individuals who present one of the highest readmission risk areas and greatest opportunity to intervene with options for palliative and/or hospice care. This can promote a more patient-centered experience while also economic benefit.<br>• This exclusion could also mean that deaths in the 30-days post-hospitalization are also excluded from the denominator, though this was not readily apparent in the draft report and should be clarified in the final report.<br>We also support the development work toward a standardized method of flagging planned readmissions through claims data for greater reliability in identification of such readmissions.<br><br>***Planned readmissions***<br>Providence is not opposed to the proposed approach to identifying planned readmissions; however, we recognize it will likely result in higher than desired calculated readmission rates. We support development work toward a standardized method of flagging planned readmissions through claims data for greater reliability in identification.<br>There are two key areas of incongruence within this methodology report we pose for your consideration:<br>• The "planned readmission" methodology does not match the current Heart Failure, Pneumonia, and Acute Myocardial Infarction CMS readmission measures, predisposing to confusion for the public in attempting to understand and interpret these measures of hospital performance.<br>• This proposed approach is not aligned with the Potentially Preventable Readmission concept that identifies those patients most at risk for readmission, providing for focused improvement effort toward a more targeted at-risk group. Clarification on how these models may work together would be of value.<br>***Organization of cohorts/eligible population definitions for "clinically coherent conditions"***<br>Organizing conditions into the seven disease-specific cohorts is appropriate and we agree with the stated rationale. Providence supports the use of the AHRQ-CCS grouper to aggregate principle diagnosis ICD9 codes into clinical groups. We believe this approach will provide a more uniform group than using MS-DRGs and will both help to direct future hospital process improvement efforts and also aid the accuracy of risk stratification. We do | | |

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| | have concern the implementation of ICD10 could impact the clinical cohort groups, as defined, and recommend a clarification on this issue in the final report.<br>***Risk adjustment model***<br>Providence has the following comments regarding the proposed risk adjustment model:<br>• The draft methodology report highlights the c-statistic performance of each of the seven models as 'consistent with other public report measures'. Apart from reporting of cstatistics in the range of 0.604 to 0.676, there is little discussion provided that addresses the model's relatively modest ability to distinguish high risk from low risk subjects and the implications for overall readmission reporting.<br>• The risk adjustment model does not fully account for multiple factors that are potent drivers of readmission risk, including variables related to relative economic health in the community, and socioeconomic status such as homelessness, lack of primary care access, low health literacy, etc. Recognizing these risk characteristics are not routinely captured in administrative databases, this limitation is a challenge to overcome. That said, we do believe these are important variables to consider in future versions of the model as electronic health record systems mature.<br>• We propose discharge status and admit source should also be taken into consideration.<br>Thank you again for the opportunity to provide comment on the Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Rate Draft Measure Methodology Report. For more information, contact Marly Christenson, System Director, Patient Safety, Clinical Effectiveness & Quality Division, Providence Health & Services [redacted]. | | |
| 8/29/2011 | This comment is being written on behalf of Duke Hospital. We appreciate the opportunity to comment on the proposed CMS "Hospital-wide 30-Day All-Cause Unplanned Risk-Standardized Readmission Rate" and recognize the inherent challenges facing YNHHSC/CORE in the development of this measure. It can be agreed upon that, to a degree, hospital readmissions are a measure of the quality of care being delivered in US hospitals, of which Duke is no exception. Without a doubt, there are instances in which the care we deliver in the hospital, and the transition out of it, result in adverse drug events, lost or missed follow-up, or other quality related issues, which subsequently lead to unplanned and preventable hospital readmission. Despite this, there are substantial difficulties that arise when trying to extend that rationale for the global use of readmissions as a reflection of the quality of care in a hospital system.<br><br>First and foremost, the extent to which readmissions can be used as a measure of quality of care is intrinsically tied to whether the readmission was preventable. After all, if the readmission is not related to a quality or system issue, one that can be subsequently improved, its utility to inform change within health systems is limited. Any methodology that attempts to calculate a standardized readmission rate must take this into account and only include potentially preventable readmissions. Unfortunately, it is unclear how many readmissions are actually preventable and estimates have ranged widely from 5-79%. (van Walraven, *CMAJ*, 2011). More to the point, attempting to define a "preventable" readmission is fraught with difficulty in and of itself for several reasons. One must first assume that preventability equals poor quality of care, which is not always the case. Take for example a patient readmitted with hyperkalemia due to excessive ACEI ingestion. If this was due to the patient having received prescriptions for multiple ACEIs upon discharge, then there is a quality issue related to medication reconciliation. If however, the patient ingested too many pills because he confused them in his pillbox, there is not a clear association with the quality of care delivery. Both scenarios are potentially preventable | Jonathan Bae,<br>Duke University Medical Center | Hospital/ health system |

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| | yet only one reflects quality. Thus, when attempting to develop a standardized rate, it would prudent to only include readmissions that were not just preventable, but preventable due to a quality related issue (for example, failed medication reconciliation). The number of readmissions that are preventable and related to quality issues is unknown but in our experience, likely represents only a small percentage. In actuality, the majority of readmissions may be related to non-clinical and social issues – such as non-adherence or lack of community support networks – that are out of the control of the hospital. As such, to hold health systems accountable for readmissions can only result in excessive expenditures to develop solutions to problems they cannot hope to fix.<br><br>Setting a benchmark for a risk-standardized readmission rate will go hand-in-hand with developing the rate itself. It is similarly problematic to determine what this benchmark should be. It is generally accepted that a proportion of patients will always be readmitted regardless of the care delivered. However, this baseline rate will be greatly influenced by the population of patients cared for by a health system. Studies have shown substantial differences in readmission rates that vary from state-to-state (Jencks, *NEJM*, 2009), by race, and whether a hospital predominantly serves minorities (Joynt, *JAMA*, 2011). These differences cannot be explained by quality of care issues alone and are more a reflection of the extensive socio-demographic issues at play. This population variability will need to be taken into account when developing a risk-standardized rate as well as the benchmarked targets such that hospitals caring for increased proportions of disadvantaged populations are not penalized unduly especially since they are probably the health systems in greatest need of support.<br><br>As it relates to methodology, the current system for determining readmission rates will require additional data sources to parse out the readmissions that have true meaning for health systems. Certain classes of readmission should be excluded from any calculations including planned/scheduled readmissions – including chemotherapy, elective surgery, radiation therapy, rehabilitation, dialysis, mental health disorders, and delivery or birth – as well as patients who leave the hospital against medical advice or are transferred to other acute care hospitals. It is unclear whether administrative data will allow CMS to identify these readmissions with that type of granularity. Much focus has been given to defining condition specific readmissions (i.e. pneumonia, acute myocardial infarction, and congestive heart failure) as a means to highlight populations at highest risk for readmission. However, defining cohorts of conditions is problematic given the heterogeneity of the populations and the sheer number of conditions included. Speaking to the Duke experience, 10 different DRGs make up the top 20% of our readmissions. But the majority of readmissions (80%) are made up of 182 different DRGs. Moreover, current methodology is limited in that it is primarily derived from administrative databases. An alternative strategy employed by the University HealthSystem Consortium (UHC) is to attempt to link readmissions as related versus unrelated using DRGs that are paired or in triplicate. Here again, the challenge lies in determining whether a readmission is truly related to the index hospitalization and whether this was due to a lapse in the quality of care. As discussed above, the readmissions of highest value to track are those that are preventable, and specifically, those that are preventable due to a quality related issue. Determining preventability is subjective and there is currently no agreed upon standard. Thus, attempts to glean “preventability” from current information systems will be severely limited and developing systems to reliably identify preventable readmissions should be a target for additional research. Whatever methodology is decided upon needs to be constructed in such a way to account for only readmissions in which a true quality issue exists as opposed to a limitation in the available | | |

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| | administrative data.<br><br>A brief note about reimbursement must be made when discussing readmissions. As already mentioned, withholding reimbursements based on higher then expected readmission rates may disproportionately affect health care systems that care for disadvantaged populations which puts them at higher risk of readmission at baseline. Additionally, consideration must be given to reforming current reimbursement models for hospital stays to promote higher quality of transitions of care. Current systems do not reimburse for transitional care programs and thus hospitals are not incentivized to focus efforts on transitions of care. Decreased reimbursements will help motivate hospitals to invest in these efforts as a means to decrease readmissions. However, developing infrastructure and changing focus to support patients once they leave the hospital is costly and time intensive. And while several interventions have shown modest successes in reducing readmissions – for example, Project RED (Jack, *Ann Int Med*, 2009) and the Care Transitions Intervention (Coleman, *Arch Int Med,* 2006) – results are difficult to generalize and they tend to be multifaceted approaches such that it is difficult to know which aspects contributed most to project success. This is compounded by the fact that current risk assessment tools cannot distinguish between those patients at moderate to high risk for readmission making it difficult to find a population to target an intervention towards. Hence, if hospitals are expected to intensify energy around discharge processes and out of hospital care, reimbursement models will need to change to help support these efforts. And of course, none of this addresses the more philosophical question of who should bear the burden. If the majority of readmissions are related to social and population issues, should the responsibility – including linked financial penalty – be held by the hospital alone or fall also to the community and possibly the patients themselves? These issues will require clarification prior to utilization of whatever risk-standardized rate is decided upon.<br><br>In conclusion, we recognize the importance of developing publicly reported measures to promote quality of care within our health systems and feel that readmission rates are one potential target. However, there are substantial barriers that must first be addressed prior to widespread use of such a measure including changes to definitions, data collection systems, and models of reimbursement. In their current diagnosis-specific form, hospital readmissions can only be loosely associated with the quality of care in our hospitals and using them to inform the public or determine reimbursements should only be done so with great caution. Extension to hospital-wide all cause unplanned readmissions will only accentuate these issues resulting in increased costs to hospitals and health care systems without the desired effect of reducing readmission and, more importantly, improving the quality of the care we deliver. | | |
| 8/29/2011 | Catholic Healthcare West (CHW) is grateful for the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS). CHW appreciates the work of CMS and Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE) in further developing a hospital-wide, all-condition, 30-day readmission measure.<br><br>CHW is a faith-based, mission-driven organization of more than 40 hospitals and medical centers in California, Arizona, and Nevada. CHW's network includes religiously-sponsored, as well as community-based, district, teaching, disproportionate share hospitals (DSH), in rural, suburban, and urban communities, representing a rich cross-section of the many types of hospitals that can be found across the nation. CHW is the fifth largest hospital system in the country and the largest not-for-profit hospital and Medicaid provider in California. As a system, approximately 41% of CHW's revenue | Rachelle Reyes Wenger, MPA<br>Director, Public Policy & Community Advocacy<br>Catholic Healthcare West | Hospital/ health system |

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| | is attributed to Medicare. CHW's network is comprised of more than 10,000 physicians, four affiliated health plans covering nearly 500,000 lives, and approximately 56,000 employees—together, delivering on a commitment that accounts for over four million patient visits annually. CHW's mission is to deliver compassionate, high-quality, affordable health care services with special attention to those facing poverty and who are underserved.<br><br>As CHW works along with the nation to advance a transformed health care system, we wholeheartedly recognize the significance of reducing preventable readmissions as they are costly and disruptive to both patients and care partners, a strain overall to the health care system, and above all, a signal that more can be done to improve assessment, planning, coordination, and delivery of care— where high, quality patient-centered care is about providing the right care at the right time.<br><br>**GENERAL COMMENTS**<br>CHW has been actively implementing efforts to reduce preventable readmissions. CHW has been engaged in a three-year project focusing on reducing 30-Day Medicare coronary heart failure (CHF), acute myocardial infarction (AMI), and pneumonia (PNU) readmisisons. Though CHW is focused on measures in these three readmission areas, improvement strategies are planned for implementation across care settings to all patients. Hospital readmission teams have received education on four major evidence-based models for readmission reduction, revised readmission review and patient interview tools, and learned about Reflective Listening as a means to better understand risks and reasons for readmission. The CHW system average for 30-Day Readmissions for the time period of July 2010 through June 2011 was 16.24%, which is slightly lower than the baseline rate of 16.8%. Readmission rates have been relatively constant showing a 3.8% reduction in FY11. Fifteen hospitals have reduced combined readmissions by more than 10%; the greatest improvement in the first year was 36.64%, showing significant improvement in CHF and PNU. Six other hospitals improved from baseline but have not yet achieved their respective targets. The range of performance (combined) is from 10.87% to 24%, AMI the lowest at 13.26%; CHF at 18.86%; and PNU at 14.34%.<br><br>Readmission rates are expected to decrease (i.e., improve) going forward. As CHW hospitals continue to implement initiatives and address challenges, (including clinician's perspective about readmissions, knowing where to focus, variability in discharge process across CHW hospitals and nursing knowledge across CHW hospitals), — gaining experience and momentum in readmission improvement efforts, CHW remains vested and engaged in the development of quality measures by CMS.<br><br>CHW recognizes the Hospital-Wide All Condition 30-Day Risk Standardized Readmission Measure (HWR) is a complex measure requiring a large data set that is not generally available to providers to replicate. Hospitals are challenged to use the generated predicted rates for quality improvement purposes given the measure does not identify specific re-admitted patients and will in all likelihood be provided only once a year**.** At minimum, if CMS is to use a measure that is not replicable by providers for pay-for reporting and payment penalties, CHW urges CMS to prioritize its efforts to create an infrastructure that would provide the data to calculate the exact risk adjusted all-patient readmission rate. CMS should provide such calculated results on a quarterly basis, rather than the annual posting currently used for the condition-specific measures, to provide hospitals more actionable data. | | |

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| | **SPECIFIC COMMENTS ON ELEMENTS OF THE HWR MEASURE**<br>CHW submits the following comments to address the areas for which CMS is specifically seeking feedback:<br>• Definition of planned readmissions<br>• Inclusion and exclusion criteria<br>• Definition of the cohort<br>• Risk-adjustment<br><br>Definition of Planned Readmissions<br>As proposed, the hospital-wide readmission (HWR) measure defines planned readmissions as any readmission that was either:<br>• A non-acute readmission in which one of 32 typically planned procedure occurs; *or*<br>• A readmission for maintenance therapy<br>32 procedures from the AHRQ Clinical Classification System (CCS) procedure category list are identified as typically planned and require inpatient stay. Readmissions in which any of these procedures are performed are considered planned if the discharge condition category is neither acute nor a complication of care. 26 discharge condition categories are identified as acute or complications of care. CHW is generally supportive of the methodology but is concerned that this methodology is not used by the existing publicly reported readmission measures for CHF, AMI, and PNU. The nonalignment of the planned readmission identification methods may confuse the public and/or result in the public not comprehending the methods and limitations of these measures.<br><br>Moreover, CHW recognizes that some of the complications (listed in Table 2), such as AHRQ CC 106 – cardiac dysrhythmias or AHRQ CC – 105 conduction disorders, may be an unavoidable and predictable post operative complication related to a procedure such as an open chest cardiac surgery, and may occur after the appropriate discharge of a patient that has been closely monitored with no relationship to quality of care. It would seem proper that these events would not be a quality of care trigger. CHW urges CMS to further clarify how such readmissions would be considered. While the methodology attempts to separate planned and unplanned readmissions in an electronic format, there will always be planned readmissions that slip through the methodology filters and into the data pool. CHW requests that the process derived allow for hospital review of cases which appear to be unplanned readmissions, with the capability existing in the system for the hospital to demonstrate an obvious planned admission that has no reflection on quality of care.<br><br>Inclusion and Exclusion Criteria<br>The five inclusion criteria and four exclusion criteria identified are reasonable. CHW appreciates that the criteria are aligned with existing publicly reported measures. CHW concurs with the addition of the inclusion criterion, that admission is not to a PPS-exempt cancer hospital. Moreover, CHW agrees with the two additional exclusion criteria, that of admissions for rehabilitation care and high competing mortality risk.<br><br>In addition, CHW also urges CMS to exclude conditions that may result in readmissions that are not “preventable” including trauma, psychoses, | | |

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| | substance use, maternity and neonatal, and end-stage renal disease. CMS should actively and quickly work with the National Uniform Billing Committee to enable CMS, and other payors, to track planned readmissions through claims and alter the measure specifications to exclude additional cases for which the hospital should not be held accountable in this measure.<br><br>Definition of the Cohort<br>CHW agrees with the grouping of patients using the AHRQ CCS. CHW is concerned with the impact of the upcoming implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) on the cohort definition. The specificity of ICD-10-CM codes may result in revisions to the currently defined cohort. CHW urges CMS to model the cohort definitions using the latest ICD-10-CM version. The results of this modeling will be beneficial to assess the impact of ICD-10-CM on these measures.<br><br>Risk-Adjustment<br>CHW appreciates CMS's stated goal for risk adjustment, which is to account for differences across hospitals in patient demographic and clinical characteristics that might be related to the outcome but are unrelated to quality of care. CHW supports risk adjusting for both case mix differences (clinical status of the patient, accounted for by adjusting for comorbidities) and service mix differences (the types of conditions/procedures cared for by the hospital, accounted for the discharge condition category). CHW does not agree with the exclusion of the patients' admission source, discharge disposition, and socioeconomic status. CHW realizes this policy is consistent with the NQF guidelines; however, CHW believes these are valid factors that may be outside the control of the hospital and should be considered even if they cannot be directly attributed to the patient.<br><br>CHW strongly agrees that hospitals should not be held to different standards of care based on the demographic of their patients. CHW very strongly believes there is only one standard of care—that is, high, quality care for all patients, recognizing and understanding also that demographic characteristics are significant not only in the way patient-centered care is delivered, but also to patient outcome (readmission measure) unrelated to quality of care.<br><br>A recent study by the California Office of Statewide Health Planning and Development of 30-Day all-cause readmissions data noted that African-American patients were more likely than any other group to have at least one readmission (42%) and on average had a larger number (2.5) of readmissions per patient per year. Hispanic patients were least likely (34%) to have at least one readmission. Caucasian patients had the lowest average number (2.01) of readmissions per patient per year. CHW urges CMS to study and take additional steps to improve risk adjustment methodologies that will hold harmless hospitals that have high readmission rates due to its patient population, to incorporate risk adjustment for socio-economic status and risk stratification for gender, race and ethnicity.<br><br>CHW appreciates the opportunity to submit comments. Should you have any questions, please feel free to contact Rachelle Wenger, Director of Public Policy & Community Advocacy [redacted] or Dr. Bruce Ermann, Medical Director of Medical Management [redacted] | | |
| 8/29/2011 | The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare and | Karen Fisher, JD | Healthcare |

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| | Medicaid Services' (CMS' or the Agency's) proposed *Hospital-Wide (All-Condition) 30 Day Risk-Standardized Readmission Measure*. The AAMC represents all 135 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians.<br><br>The AAMC is supportive of CMS' efforts to reduce hospital readmissions. Earlier this year, the Association launched a comprehensive effort, known as the Best Practices for Better Care (BPBC), to enlist medical schools, hospitals, and health systems to implement five initial best practices to improve health care at our member institutions. One of these best practices is reducing readmissions for high-risk patients through increased contact and documentation with the patient.<br><br>**RISK ADJUSTMENT**<br>CMS asserts in the draft measure methodology report that they "did not adjust for socioeconomic status, gender, race, or ethnicity because hospitals should not be held to different standards of care based on the demographics of their patients." The AAMC is disappointed in CMS' rationale and we believe that appropriate risk adjustments are necessary to account for these differences in the patient population.<br><br>It is increasingly apparent that socio-economic status (SES) is indeed associated with patient outcomes, yet CMS fails to account for these factors, which include income levels, education levels, poverty, and literacy rates in this readmission measure. Ignoring patient demographics creates an uneven playing field for providers that treat sicker and more vulnerable patients, such as teaching hospitals. Inclusion of these and other indicators is critical to ensuring that providers who treat more vulnerable patients are accurately and fairly assessed.<br><br>The measure methodology also proposes to use the Agency for Healthcare Research and Quality (AHRQ) Condition Classification System (CCS) to group hospitalizations into clinically coherent, mutually-exclusive, condition categories according the principal diagnosis for use in seven risk models. The AAMC appreciates the use of multiple models to determine risk and remove the variation that would exist in a single model. However, the AAMC has some concerns regarding the condition categories and whether or not they will adequately account for complex patients with multiple co-morbidities typically seen at teaching hospitals. The draft methodology did state that testing is being conducted and will be available in September. We urge CMS to release the results of the testing and make them publicly available. Reviewing the testing results can reveal whether the condition categories appear to be an appropriate grouping for determining risk amongst complex patients and determine if further adjustments need to be made.<br><br>Last, the HWR measure calculation is based on Medicare claims data similar to the current readmission measures. While we understand the need at this time to utilize claims data, they are less than adequate in determining patient risk as the Medicare file only captures nine diagnosis codes. This is especially detrimental for measuring complex patients with multiple comorbidities.<br><br>We have heard that CMS is seeking to modify the way in which claims data are captured and will ultimately report 25 diagnosis codes as opposed to the current nine. The AAMC strongly supports this modification that will not only improve the risk calculation for the HWR measure but other claims- | Senior Director and Senior Policy Counsel<br>Association of American Medical Colleges | association |

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| | based measures included in the various hospital quality reporting programs.<br><br>**LIST OF EXCLUDED PROCEDURES**<br>In addition to the specific conditions excluded for the Hospital Wide Readmission (HWR) measure, we urge CMS to include in this list all readmissions that are part of a natural disease or treatment progression or are the result of a non-hospital related factor (including a patient's characteristics and home environments). That being said, we urge CMS to exclude the following condition categories from the readmission measure: congestive heart failure, trauma, burns, ESRD, sepsis, psychoses and mental health diagnoses, and substance use.<br><br>**PLANNED AND RELATED READMISSIONS**<br>The AAMC appreciates CMS' recognition that planned readmissions should not be included in the readmission measure and as stated in the draft methodology report do not indicate a *quality signal*. However, it is still unclear how related readmissions will be counted. Specifically how will the HWR measure characterize admissions that do not fit within the definition of a planned admission and are also not an acute admission?<br><br>**READMISSION TIMEFRAME**<br>The AAMC understands CMS' interest in aligning the HWR readmission time period with other current readmission measures. However, the AAMC is concerned that the 30-day timeframe will be the standard for all readmission measures. We continue to believe that readmission measures should be calculated based on the 7-14 day time period where the hospitals have the most control and readmissions are not significantly influenced by outside factors.<br><br>The AAMC appreciates the opportunity to provide comments on the proposed Hospital-Wide (All-Condition) 30 Day Risk-Standardized Readmission measure. If you have any questions or issues regarding our comments, please feel free to contact Jennifer Faerberg [redacted] | | |
| 8/29/2011 | Vanderbilt University Medical Center (VUMC) welcomes this opportunity to comment on measure under development: Hospital-wide Readmission by the Centers for Medicare & Medicaid Services (CMS) and the Yale New haven health Services Corporation/ Center for Outcomes Research & Evaluation (YNHHSC/CORE).<br><br>VUMC has built a strong reputation as a leader in medical education, research, and patient care throughout the Southeast and the nation over the course of its 135-year history. At its heart the VUMC is driven by discover and the immediate incorporation of new knowledge into innovation in patient care and physician and nurse education. We see more than a million outpatient visits and more than 50,000 hospital admissions per year. Our Emergency Departments for adults and children are treating more than 100,000 patients a year. A principal referral center for physicians and patients throughout the region, Vanderbilt University Hospital and the Vanderbilt clinics consistently rank among the premier health-care facilities in the United States. | Julie Morath, RN, MS<br>Chief Quality and Patient Safety Officer<br>Vanderbilt University Medical Center | Hospital/ health system |

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| | Comment to Section 2.5: Risk Adjustment<br>CMS has noted that assignment of a patient to one or more HCCs is based on the severity of the patient's illness as documented and coded with the ICD-9-CM diagnosis coding system.<br>If the ICD-9-CM diagnosis coding system is limited to the first ten codes, VUMC is concerned that the MedPar data does not accurately reflect the severity of illness of its patients and its position within the risk model.<br><br>To gain an understanding of the impact of limiting the data to only the first ten ICD-9 diagnosis codes, VUMC analyzed its over 65 Medicare patient population using internal data and found a significant number of codes that would be lost.<br><br>As an example, VUMC used its internal data to identify patients with COPD (490, 491.0, 491.1, 491.2, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 494, 494.0, 494.1, 496). 24% of the COPD codes were found in ICD-9 codes 11 and beyond which would not have been indentified using the MedPar data.<br>Comment to Section 2.6: Statistical Approach to Model Development<br>In the interest of continuous improvement, please specify the predicted and expected models in tables including coefficients, confidence intervals, p-values, and standard errors.<br><br>Conclusion<br>VUMC appreciates this opportunity to comment on the proposed Hospital-wide 30-Day All-Cause Unplanned Risk-Standardized Readmission Rate. If VUMC can provide any further information, or if there are any questions or concerns with regard to this letter and its recommendations, please contact me [redacted] | | |
| 8/29/2011 | General Comments: The goal is to propose a claims-based, risk adjusted hospital-wide readmission (HWR) measure for public reporting that reflects the quality of care for hospitalized patients in the United States.<br>Several of our concerns relate to the risk adjustment methodology.<br>• The risk adjustment model does not take into account significant and well-recognized reasons for readmission which are not attributable to "quality of care" (page 8), These include disease progression, patient characteristics (socio-economic and demographic), and failure of the ambulatory environment and patient access. "The numbers and interrelationships of chronic conditions to be managed outside of the hospitalization, i.e. access to primary care and patient characteristics such as functional status, patient activation and healthcare literacy, are major drivers of readmissions even after optimal care in the hospital." While some of these factors may be improved with broader healthcare reform such as expanded access and accountable care organizations, these reforms have not yet been broadly implemented. As such, organizations caring for a larger number of high risk patients may be unjustly penalized. Some of these could be, but are not, adjusted for in the | Daniel J. Brotman, MD, FHM, FACP<br>Director, Hospitalist Program<br>Johns Hopkins Hospital<br>Associate Professor of Medicine | Hospital/ health system |

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| | Yale proposal. A relatively straightforward example is socio-economic status for which there are well-defined criteria, which are not at all impacted by quality of inpatient care, and which are known to significantly influence readmission rates. The explanation offered is that "hospitals should not be held to different standards of care based on the demographics of their patients." We agree, of course, but adjusting for socio-economic status does not equate with different standards of hospital care. In fact, failure to adjust for known and easily identifiable readmission risk factors outside of hospital control may have the unintended consequence of encouraging hospitals to limit the admissions of these higher risk patients.<br>• It appears that co-morbid conditions are only assessed using data from the index admitting diagnoses and any admission in the prior 12 months. "We adjusted for case mix differences among hospitals by risk-adjusting for patients' co-morbid conditions identified in inpatient episodes of care for the 12 months prior to the index admission as well as those present at admission." Yet diagnoses are often made *during* the index admission which may importantly (and arguably are more likely than 12-month prior diagnoses) to impact 30-day readmission rates. Thus, we believe that co-morbid conditions diagnosed during the index admission should also be included in the adjusted model.<br>• The definition used for "complication of care" appears too broad. The first example provided is a patient admitted with sepsis who undergoes a cholecystectomy. This might be better defined as a complication of the diagnosis, cholecystitis. Furthermore, the definition does not take into account the risks associated with a procedure, which we believe should be included in the risk adjustment model. Thus "complications" might be more likely following a neurosurgical, than a general surgical, procedure.<br><br>Given these concerns, we believe it is important to conduct a sensitivity analysis for various risk adjustment models evaluating the extent to which they discriminate, and calibrate. In addition, CMS should evaluate the extent to which these risk adjustment models impact hospital level performance. Both the public and providers should be aware of the extent to which risk adjustment impacts performance.<br>• Time Frame: The time interval to measure hospital attribution for readmissions should be no longer than 15 days. Although the literature is disparate on the time interval that most closely correlates to problems evolving from an initial hospitalization, most agree that the further the re-admission is from the index hospitalization, the more likely it is attributable to chronic disease progression, socio-economic factors, and failure of the outpatient environment. Hospital readmissions cluster shortly after discharge (1-7 days) and decline thereafter.12 Evaluation of readmission rates for Johns Hopkins Health system shows that 66% of the 30-day readmissions occur within 15 days of the initial hospitalization, with the largest proportion of readmission within the 1-7 day period. As such, CMS should consider creating a measure for readmission with 7 days which reflects the quality of hospital care and the transition of care, and a measure for readmission with 30 days which reflects the broader public health concerns. Both measures could be reported with little additional costs, and provide deeper insights into preventable readmissions attributable to in-patient care.<br>• Planned Readmissions: This list is extremely limited. There are categories that are excluded that should not be, especially related to surgical procedures for an underlying cancer diagnosis. **Examples include: 527 Rad pancreaticoduodenectomy (CCS 99), 5022 Partial hepatectomy (CCS 99), 0159 Other Brain excision (CCS 1), 304 Radical laryngectomy (CCS 42).** There are also planned "staged" procedures that are not included, such as spinal surgery. ***CMS should exclude patients that have scheduled readmissions.*** | | |

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| | • Issues specific to Maryland: As Maryland hospitals have a single provider number for those facilities with on-site psychiatric, rehabilitation, and oncology hospitals, methodology must be accurate to exclude transfers to these "services" without being counted as a readmission. The Johns Hopkins Oncology Hospital is not a designated PPS Oncology Center, and thus would not be excluded from this readmission methodology, (although it should be). For this measure to be accurate, it is important that hospitals are able to comment on which of their facilities to include and which to exclude. ***CMS should ensure that hospitals have an opportunity to ensure the facilities included in these analyses are appropriate.***<br>• Unintended consequences: As we move forward with the implementation of care coordination strategies to reduce readmissions, we believe we must also pay close attention to the development of unintended consequences. It is quite possible that acute care length of stay will increase due to pressures to address all issues related to ambulatory and chronic conditions during the hospitalization. Pressures on Emergency Departments to treat and discharge patients may be increased especially where access to primary care is problematic. The planned expansion of patients on Medicare will worsen this problem. Unnecessary invasive procedures and diagnostic studies may be performed to avoid readmissions for those traditionally "watch and wait" conditions. More seriously, there may be delays in timely care for sick patients while alternative strategies are employed. Finally, there may be a risk of increased mortality due to delay in needed care while trying to avoid rehospitalization. Indeed, several surgeons have expressed their concern about the potential for this measure to harm patients. They believe that when patients suffer a complication, they should be encouraged, not discouraged from getting appropriate care, usually in a hospital. While some of those complications may be preventable, a more focused effort on reducing preventable complications may improve quality of care and reduce the risk for unintended patient harm. A scalpel rather than a hammer may be needed. Indeed, a recent important study revealed that a "higher occurrence of readmissions after index admissions was associated with lower risk-adjusted 30 day mortality" and "a higher readmission rate may be a consequence of successful care." CMS should create a robust mechanism to monitor for unintended consequences in a variety of medical and surgical patient populations.<br><br>The fundamental reasons for readmissions most directly attributable to hospitals are inadequate care coordination and poor quality of inpatient care rather than broader aspects of public health. If the principal objective of the CMS proposal is hospital performance improvement, readmission measures should focus on these two areas. Patient characteristics, chronic disease progression, and failure of the ambulatory environment, while important reasons for rehospitalization, are under limited control of the acute care organization alone. Readmissions as a clinical outcome are both a **quality** and a **utilization** indicator. While we need to understand both dimensions, it is in the area of quality that acute care organizations can have the greatest impact. We want to be held accountable for the quality of inpatient care and care coordination we provide. We want the measure used to evaluate that quality to be scientifically sound. Patients and providers deserve nothing less. | | |
| 8/29/2011 | Kaiser Permanente appreciates the opportunity to comment on the 30-day all-cause risk standardized hospital readmission rate under consideration by CMS and posted at https://www.cms.gov/MMS/17_CallforPublicComment.asp#TopOfPage. | Andy Amster<br>Director, Center for Healthcare Analytics<br>Department of Care and | Hospital/ health system |

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| | Kaiser Permanente is the largest private integrated healthcare delivery system in the United States, delivering health care to approximately 8.6 million members, in nine states and the District of Columbia. Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its Health Plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 36 hospitals and over 400 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with the Kaiser Foundation Health Plan to meet the health care needs of Kaiser Permanente's members.<br><br>Kaiser Permanente's comments are general, and focused on (a) whether there is a need for another all-cause hospital readmission rate measure when an analogous measure—the HEDIS Plan all-cause readmission rate (PCR)-- exists and has been endorsed by the National Quality Forum; and (b) the problems created by measures constructed from Medicare Part A claims for hospitals whose Medicare beneficiary patients are largely enrolled in Medicare Advantage plans.<br><br>Kaiser Permanente serves approximately 1 million Medicare beneficiaries enrolled in the Medicare Advantage program and Medicare cost contracts. When Kaiser Permanente Medicare Advantage enrollees are served in the 36 Kaiser Foundation Hospitals, a Part A claim is not submitted to CMS; instead, Kaiser Permanente is paid a monthly capitation rate by CMS to provide Part A, B, and D benefits for each of the Medicare beneficiaries enrolled in our Medicare Advantage plans. Consequently, the 36 Kaiser Foundation Hospitals do not treat many Medicare beneficiaries for whom they submit Part A fee-for-service payment claims to Medicare. Quality measures that are constructed on Part A fee-for-service claims data do not and will not reflect the experience of the overwhelming majority of Medicare beneficiaries served by our hospitals, physicians and health plans.<br><br>The Kaiser Foundation Hospitals' experience to date is with the Inpatient Quality Reporting (IQR) program, whose process of care and other clinical measures are based on Medicare Part A claims data. Based on that experience, the KFH hospitals cannot meet the volume thresholds or generate valid and meaningful results because the Medicare beneficiary population treated in these hospitals is largely comprised of Medicare Advantage plan members, for whom no Medicare FFS Part A claims are submitted. Kaiser Permanente and its affiliated hospitals are not the only delivery systems that serve Medicare beneficiaries primarily under the Medicare Advantage program. CMS should be concerned that measures based on Medicare FFS Part A claims are not capturing the inpatient experience of millions of beneficiaries who are enrolled in Medicare Advantage plans. Hospitals that care for Medicare Advantage plan members do not submit Medicare FFS Part A claims, and therefore, the experience of these hospitals and these beneficiaries will not be included in this rate as presently configured.<br><br>We urge CMS to refrain from introducing a new readmission measure into a quality measurement and reporting landscape that is already very cluttered. An all-cause readmission measure that is not based on Medicare FFS Part A claims data already exists under HEDIS, and has been endorsed by the National Quality Forum and tested and reported by health plans through the National Committee on Quality Assurance (NCQA). Medicare Advantage plans like most of the Kaiser Foundation Health Plans are reporting this HEDIS measure now to CMS, and CMS is considering adding this | Service Quality, Kaiser Permanente | |

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| | measure to the 2012 star rating composite measure of quality for Medicare Advantage plans. In addition, CMS' Medicare Drug and Health Plan Contract Administration Group notified Medicare Advantage Organizations (MAOs) on August 18, 2011 that MAOs will be expected to have a Quality Improvement Plan (QIP) that address plan members' hospital readmission rates in 2012, using the HEDIS all-cause readmission measure.<br>Kaiser Permanente is also concerned that the introduction of another all cause readmission measure, unless it is properly vetted and endorsed by the National Quality Forum and aligned with other measures across the Medicare program and private sector efforts, would not be in the spirit of the Secretary's National Quality Strategy released in March, 2011<br><br>http://www.healthcare.gov/center/reports/quality03212011a.html. The National Quality Strategy (NQS) states that "care delivery and outcomes should be measured using consistent, nationally-endorsed measures in order to provide information that is timely, actionable, and meaningful to both providers and plans." The NQS also pledges that "efforts will focus on aligning measurement efforts within value-based purchasing programs and will move toward measuring outcomes and patient experience." | | |
| 8/29/2011 | The National Association of Children's Hospitals and Related Institutions (NACHRI) is pleased to have the opportunity to offer comments on the Draft Measure Methodology Report for the Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure. We offer these detailed comments in response to the Centers for Medicare and Medicaid Services (CMS) call for public comments, which was issued on August 22, 2011 with a response date of August 29, 2011.<br><br>The draft proposed Hospital-Wide Readmission (HWR) system has been developed as a possible next level approach to readmissions for the Medicare program for patients 65 years of age and older. Children's hospitals treat relatively few Medicare patients, but the HWR proposal is of great interest because of the central role of Medicare in the U.S. healthcare delivery system and, specifically quality measurement, and because the proposal specifically speaks of adapting the HWR for all-payer datasets.<br><br>NACHRI has a number of concerns with the specific methods of the draft proposed HWR system, the overall approach of moving from a condition-specific system to an all-cause system, and the extent of testing and validation. NACHRI believes the approach should be incremental, learning from the initial approach that featured three high volume conditions and building on this with improved methods. NACHRI believes it is premature to move from a three condition system to an all-cause system (all causes except those that can very specifically be identified as planned).<br><br>We present a high level summary of NACHRI's concerns and recommendations, focusing on the proposed outcome measure (all-cause 30-day readmissions), the four specifically requested areas for comment, the approach to testing and evaluation, and adaptation for all-payer application. Then, we present a brief overview on pediatrics and hospital readmissions, an outline of key concepts and principles for design of readmissions measurement systems, and a detailed set of comments, questions and suggestions for the 8/10/11 Draft Measure Methodology Report.<br><br>**SUMMARY**<br>1. Proposed Outcome Measure, Hospital-Wide (All Condition) 30-Day Risk-Standardized Readmission Measure: NACHRI does not support the proposed all-cause 30-day readmission system as a measure of hospital quality performance for public comparative reporting or payment. | Lawrence A. McAndrews<br>President and CEO<br>National Association of Children's Hospitals and Related Institutions | Healthcare association |

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| | Rather, NACHRI supports the development of readmissions measurement systems that are focused on readmissions that are related to the conditions treated in the prior hospitalization and are potentially preventable by the actions of the hospital.<br>2. Definition of Planned Readmissions: NACHRI believes the proposed definitions for planned readmissions are conceptually flawed and the specifications are very incomplete. The concept of planned admissions is much too narrow to be the sole clinical basis for identifying hospitalizations to be removed from the candidate pool of potentially preventable readmissions.<br>3. Inclusion and Exclusion Criteria: Five of the seven exclusion criteria are straightforward and logical given the purposes of the readmissions system. NACHRI has two recommendations.<br>a. For the same reasons that PPS-exempt cancer hospitals are excluded from the proposed HWR system ("care for a unique population of patients that is challenging to compare to other hospitals"), NACHRI recommends that PPS-exempt children's hospitals be excluded.<br>b. NACHRI recommends expanding the exclusions for malignancy hospitalizations, and lowering the "high competing mortality risk threshold" in the 30 days post-discharge period from 50% to somewhere in the range of 25% based upon sensitivity analysis.<br>4. Definition of Index Admission Patient Cohorts: NACHRI does not support the use of the AHRQ Clinical Classification System (CCS) as the basis for defining patient cohorts. Many of the categories are very broad and heterogeneous, very little information is provided about the evaluation that led to the selection of the CCS, and the system is not regularly used by hospitals. It is also not clear how patients with multiple surgical procedures are classified. NACHRI recommends further exploration and testing of alternative classification methods.<br>5. Risk Adjustment: NACHRI does not support the proposed methods for risk adjustment. In NACHRI's view, the proposed methods do not fully describe the reason for admission, the acuity of the index hospitalization, the full extent of complex chronic conditions, the impact of technology dependent conditions, or the impact of family, social and psychological factors. NACHRI recommends the development of a more robust clinical model, and one that will yield more recognizable and actionable information by users.<br>6. Evaluation and Testing: There is only a brief discussion in the proposal document about testing and evaluation. NACHRI believes it is essential that there be a full testing and evaluation of the proposed system. This should have two components: (a) statistical testing of readmissions patterns for biased subgroups of patients and hospitals, and (b) case level testing to ensure that the system is excluding and including the intended patient populations and that the readmissions represent cases that are potentially preventable by the actions of hospitals.<br>7. Adaptation of Proposed HWR System for All-Payer Applications: The proposed HWR system is developed specifically for the 65+ year old Medicare population, and NACHRI does not believe this can be easily adapted for all-payer applications. Evidence of this is that the less than 65 year old Medicare population (the SSI disabled) were excluded from the model development on the basis that, "younger Medicare patients represent a distinct population with dissimilar characteristic and outcomes."<br>**I. <u>Brief Overview and Perspective on Pediatrics and Hospital Readmissions</u>**<br>Over the last several years, NACHRI and others in the pediatric community have been performing analyses to create a better understanding of the children who are hospitalized, those who are hospitalized more than once including short interval readmissions, the reasons for readmissions, readmissions that may be preventable, and risk factors for multiple hospitalizations. A number of articles are beginning to be | | |

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| | published in the peer reviewed literature about pediatric readmission patterns (e.g., J. Berry, C. Feudtner, and J. Gay).<br><br>To briefly summarize, relatively few children are hospitalized and most children who are hospitalized have only one admission. However, there are subsets of children, mostly those with complex and multiple chronic conditions and technology assistive devices, who often have multiple hospitalizations. In children's hospitals at least, multiple hospitalizations and short interval readmissions are dominated by children with complex and multiple chronic conditions. There are also readmissions for children with acute illness only conditions, but this is a relatively small part of total readmission activity. Initial analyses identify that most of the readmissions pertain to ongoing disease processes. Initial analyses (chart review level) link only a small percentage of readmissions to inadequacies in the inpatient care and discharge planning. There is some thinking that there may be greater opportunity for improvements through expanded care coordination services in the outpatient setting. This also will sometimes require agreement to pay for expanded care coordination services and home health services. There is much yet to learn about what is possible with the coordinated effort of all providers and payers.<br><br>Other important activity is occurring as a result of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA established a new AHRQ Pediatric Quality Measures Program with grants to Centers of Excellence to develop an expanded and enhanced set of core quality measures for children. This program began in early 2011 and includes projects to develop a variety of inpatient and outpatient quality measures, including pediatric readmissions measures.<br><br>Part of what NACHRI has learned from all this work is the tremendous complexity in understanding hospital readmission patterns and designing appropriate systems to measure what we are attempting to measure - i.e., potentially preventable readmissions. The effort needs to include methods to define distinct index admission patient cohorts, methods to classify and judge readmissions in terms of being related and potentially preventable, and methods to risk adjust for potentially preventable readmissions. To do this, all of the information on the hospitalization discharge abstract needs to be considered, not just principal diagnoses and procedures. In judging what is potentially preventable, the system must also judge what is significantly within the influence of the inpatient care providers versus outpatient providers and the larger care delivery system.<br><br>**II. <u>Key Concepts and Principles for Design of Readmissions Measurement Systems</u>**<br>NACHRI believes the following are key concepts and principles for the design of readmissions measurement systems. These concepts and principles serve as the framework for our detailed comments and suggestions on the CMS draft proposed HWR system.<br>1. Readmissions should be related to conditions treated in the prior hospitalization and to a significant extent should be potentially preventable.<br>2. Time windows for readmissions should be relevant and significantly within the influence of the hospital.<br>3. Readmissions systems should be tested and validated for the intended patient populations, especially subgroups that may be systematically at greater risk for readmissions. | | |

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| | 4. The approach to the use of administrative data should seek to maximize the use of information from the index admission and certain information from the readmission hospitalizations (e.g., chronic conditions). In addition, the approach should incorporate information from prior hospitalizations when this is available and a practical option.<br>5. Fully developed risk adjustment methodologies are essential in rate-based measurements, such as readmissions. Otherwise, rate based comparisons will be biased, unhelpful and unfair. Risk adjustment needs to take into account:<br>a. Reason for admission.<br>b. Acuity of hospitalization, taking into account principal and secondary diagnoses and procedures.<br>c. Complex and multiple chronic health conditions.<br>d. Technology dependent conditions.<br>e. To the extent possible - family, social, and psychological factors.<br>6. Readmissions systems should generate information about the potentially preventable readmissions that is clinically recognizable and relatively easy to interpret and act upon for improvement strategies.<br><br>**III. <u>Detailed Comments and Suggestions for 8/10/11 Draft Measure Methodology Report, "Hospital-Wide 30-Day (All Condition) Risk Standardized Readmission Measure"</u>**<br><br>**1. <u>Proposed Outcome Measure, All-Cause 30-Day Readmissions (Sections 1.1-1.3 and 2.1-2.2)</u>**<br><br>The proposed outcome measure is, "unplanned all-cause 30-day readmissions after an admission for any condition".<br><br>It is NACHRI's view that the unplanned all-cause 30-day approach to readmissions is much too broad, unfocused and unsubstantiated to serve as a measure of hospital quality for public comparative reporting or payment.<br><br>Introductory Sections 1.1-1.3 provide a general statement of rationale and Methods Sections 2.1-2.2 provide a more specific description and rationale for the proposed all-cause 30-day readmission measure, but neither in our view makes a convincing case for the proposal.<br><br>Section 1.2, Hospital-wide Readmission as a Quality Indicator, presents the proposal's general perspective on hospital readmissions and the proposed outcome measure. Its opening statement to frame the topic is, "Hospital readmission, for any reason, is disruptive to patients and caregivers, costly to the healthcare system, and puts patients at additional risk of hospital-acquired infections and complications." This perspective would support an all-cause 30-day readmission measure, but we don't believe this is a fair or helpful framing of the topic. It could be said that almost all serious illnesses and all hospitalizations are disruptive to patients and caregivers, not just readmissions. This is not the issue. The issue is how to identify hospital readmissions that are likely preventable and within the significant influence of the hospital.<br><br>The last paragraph of Section 1.2 concludes, "Given that studies have shown readmission within 30-days to be related to quality of care, and | | |

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| | that interventions have been able to reduce 30-day readmission rates, it is reasonable to consider an all-condition readmission rate as a quality measure." We certainly agree that some readmissions for some patients can be prevented, but that does not substantiate a basis for the proposed all-cause 30-day readmission system to be a comparative quality measure of hospital performance.<br><br>The proposal document does not put forward its own analyses to substantiate the *proposed **all-cause approach***. Rather, at the end of Section 2.2, Outcome Definition, the proposal puts forward six very general reasons for selecting an "all-cause" approach over a "related" approach. It cites that from the patient perspective, readmission for any reason is likely to be an undesirable outcome of care. We don't think this is necessarily the case. Hospitalization may be what is needed and unavoidable to treat the patient's condition. The question is not about whether the patient desires another hospitalization, but whether the subsequent hospitalization could have been prevented by the actions of the hospital. It then cites the difficulty of specifying a comprehensive list of all that may be considered "related" as a reason for not attempting to do this, but defining what is related and what is potentially preventable is the crux of the matter. If the readmissions measurement system does not try to do this, then how does the hospital know what the system is measuring and how does the hospital know how to best target their improvement efforts?<br><br>It is important to emphasize that it is not enough for the readmissions system to identify what is "related". It must also identify what it considers to be "potentially preventable". To illustrate, a patient admitted for treatment of cancer may be readmitted for conditions such as neutropenia or aplastic anemia. This is clearly related, but there may be little that is preventable about the readmission.<br><br>The rest of the reasons put forward are also very general and not very persuasive. It cites consistency with CMS's existing measures, but this does not validate the existing measures, much less substantiate extending the same approach on a hospital-wide all-cause basis. It also cites encouraging broader hospital-wide approaches, but to do so does not require a hospital-wide all-cause approach that does not target opportunities of greatest potential impact. Lastly, it cites the need to assess hospital performance against what is "expected", but again since expected is defined without the rigors of what is related and potentially preventable, it's hard to tell how meaningful this would be.<br><br>To summarize, NACHRI believes that readmissions measurement systems must focus on readmissions that are related and to a significant extent potentially preventable. NACHRI believes this is central to the validity and credibility of readmissions systems. This is probably the most difficult part of developing readmissions measurement systems, but cannot be skipped over.<br><br>The ***choice* of *time window*** (7, 15, 30 days) is another important parameter and has implications for what kinds of readmissions are included and how much the hospital can directly influence them. The longer the time frame the greater the influence of chronic conditions, family and social factors, and the organization, delivery and financing of outpatient and home care services. To illustrate, in one study of 15 day readmissions to a children's hospital, it was identified that for 0-7 day readmissions a relatively higher percentage of cases were for acute illness only conditions, and for 8-15 day readmissions a relatively higher percentage of cases were for chronic conditions and planned hospitalizations. | | |

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| | The selection of time window is not straightforward or simple. It needs to be done in conjunction with the approach to what is counted as a potentially preventable readmission. The ideal system would tailor the time window to the specific measure. To illustrate, readmissions for infectious conditions that have short incubation periods such as bronchiolitis are relevant to include if they occur within one week of discharge. In contrast, patients admitted for ventricular shunt procedures may have obstructions that occur for a longer time after discharge and so a longer time window is justified.<br><br>If the readmissions system is not designed to accommodate different time windows, then adjustments need to be made. To illustrate, in the instance of bronchiolitis, if a one week time interval cannot be differentially specified by the system then bronchiolitis should only be allowed to count as a potentially preventable readmission in limited circumstances such as a readmission to a previous admission of bronchiolitis or closely related respiratory condition. Otherwise, the system is likely to be picking up mostly community acquired bronchiolitis, one of the more common causes of hospitalization in young children, and which is not attributable to the quality of inpatient care or discharge planning.<br><br>In the instance of the draft proposed HWR, the approach is all-cause, whether related or not, just as long as it is not specifically identifiable as planned. For this kind of system (which we do not support) or other very broad based systems in which attribution is uncertain and the intent is to use for comparative reporting or payment, we *recommend* that a *7 or 15 day time window* rather than 30 days should be used at least until such time as it can be demonstrated that the longer time window is warranted.<br><br>The proposal document puts forward *three reasons* for a 30-day time interval in Section 2.2.2, but none actually substantiates the case, especially in the context of an all-cause system. The *first* reason stated is, "Within a 30-day time frame, readmissions are more likely attributable to care received during the index hospitalization and during the transition to the outpatient setting". It goes on to say, "A number of studies have demonstrated that improvements in care at the time of patient discharge can reduce 30-day readmission rates". These are both very general statements. No substantiation is provided for the initial statement that 30-day readmissions are "more likely attributable to care received during the index hospitalization and during the transition to the outpatient setting", and no specifics are provided as to whether the impact of hospital activities is predominantly on the first week or two weeks after discharge versus the third and fourth weeks.<br><br>The *second* reason stated is that 30-days is consistent with other readmissions measures reported by CMS or by NQF. This may be true but doesn't substantiate the other measures, and more importantly, doesn't substantiate its application to this very broad all-cause context for hospital quality measurement reporting. It is important to distinguish that what may be helpful from a health plan perspective is different from that of an individual hospital, and what may be helpful for quality improvement may not be helpful for the purposes of comparison. A health plan is responsible for all services by all providers within its insured scope of benefits for its insured populations. Accordingly, it is useful for the health plan to examine all hospitalizations including hospital readmissions as part of its activity to track and assess utilization patterns for inpatient, outpatient, and home healthcare services. This is different than for a hospital which is providing inpatient services | | |

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| | for selected patients and does not control the care delivery networks and providers or determine the covered services.<br><br>The *third* reason stated is a review and interpretation of "time to event" curves. It is difficult to view exact changes in readmission rates over time periods from Figure 1, but it is clear that there are many more readmissions in weeks one and two than weeks three and four, with probably about two-thirds of the readmissions occurring during the first two weeks. The conclusion statement is made, "Curves typically stabilize within 30 days of discharge, indicating that a 30-day cutoff is clinically reasonable". It's not clear how this statistical analysis leads to the conclusion that 30 days versus 20 days or 15 days or some other time window is best, but at a minimum this kind of analysis needs to be coupled with more in-depth analysis of the kinds of readmissions that are occurring in the third and fourth weeks and the extent to which hospitals can influence their occurrence. The application is also important to consider. If the results of the system are to be used for public reporting or payment for hospital services, then the measure needs to reflect what is reasonably within the control or influence of the hospital.<br><br>**2. <u>Definition of Planned Readmissions (Section 2.2.1)</u>**<br>Two kinds of planned readmissions are defined. One is readmissions in which a procedure from a pre-specified list of surgical procedures is performed, except that the procedure does not count as planned if the admission is for acute illness or complications of care. The second is readmissions for maintenance chemotherapy.<br><br>In NACHRI's view, this overall approach to planned readmissions is conceptually weak. It also is incompletely specified, including only 33 of 103 AHRQ CCS surgical categories and only certain of the codes for chemotherapy.<br><br>The *concept of planned readmissions* is much too narrow to be the sole clinical basis for identifying hospitalizations to be removed from the candidate pool of potentially preventable readmissions. In the instance of surgical procedures, the operation may not always be planned but may be done on an urgent or emergent basis. That a surgical procedure is done on an urgent or emergent basis does not make it potentially preventable. There are many circumstances where a patient may be admitted to the hospital, treated medically, and then readmitted at a later time for surgery. It may often be the conservative approach to defer a decision about surgery or to give the patient more time. Subsequent hospitalizations for surgery can also be unrelated, either for trauma or unrelated illness.<br><br>To classify a readmission for surgery as a potentially preventable hospitalization, there needs to be specific clinical logic that identifies the situations viewed as potentially preventable. This is very different from the proposed approach of the HWR system which is to count all surgical readmissions except those that can be specifically identified as planned and removed from the system. To illustrate:<br><br>If the readmission for surgery is for a complication of care from the first hospitalization, then yes it is reasonable to count the readmission as potentially preventable. To assess this, it would be necessary to examine and make a judgment based upon the PDX of the readmission hospitalization or based upon the relationship of the surgery in the first hospitalization to the surgery in the second hospitalization. | | |

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| | The approach to chemotherapy is also narrow and limiting. The specifications only include the V code diagnoses for admission for chemotherapy and radiotherapy and procedures for therapeutic radiology for cancer treatment. It does not include other patients with procedure codes for receiving chemotherapy as part of their inpatient treatment. These are hospitalizations that are either "planned" or part of the treatment for the condition, and are not useful to count as potentially preventable readmissions.<br><br>More broadly we believe the approach to the classification of readmissions for cancer patients is flawed. The treatment for many malignancies involves multiple hospitalizations, often within short time intervals. A patient with an aggressive cancer may require very aggressive treatments with many side-effects and multiple hospitalizations, if they are ultimately to survive. Quality needs to be viewed moreso in terms of multi-year survival than short time interval readmissions.<br><br>To clarify, we are not saying that all admissions for all patients with any diagnosis of cancer need to be excluded from readmission measurement systems. To illustrate, it may be appropriate to include certain cancer patients receiving certain kinds of surgery, and cancer patients who are not receiving chemotherapy provided they do not have certain more aggressive cancers or metastatic cancer.<br><br>The key point is the focus needs to be on potentially preventable hospitalizations and there needs to be a clinical model with detailed clinical specifications to distinguish these different circumstances. Otherwise, the system will produce a great deal of confusing and unhelpful output for users to sort through and try to make sense of.<br><br>In addition to our concerns about the conceptual approach to the use of planned procedures as part of the proposed HWR, we have concerns that the ***specifications*** of Table 1 Planned Procedure List is ***are incompletely developed***.<br><br>There are some surgical areas that seem to be entirely missing from Table 1. These include:<br>• Brain surgery<br>• Other neurosurgery<br>• Eye surgery<br>• Ear, Nose, Mouth & Throat surgery<br>• Cranial-Facial surgery<br>• Liver surgery<br>• Pancreas surgery<br>• Spleen surgery<br><br>Among those surgical areas included in Table 1, there are a number of important surgical procedures that are missing. These include:<br>• Surgery for major congenital heart defects.<br>• Orthopedic surgery for factures, dislocations, congenital deformities, and other diseases of hip & femur, low limbs and upper limbs | | |

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| | (only hip and knee replacements and arthroplasty procedures are included).<br>• Many GI procedures such as appendectomies create esophogastric sphincter competence, anal sphincter repair, colostomy, ileostomy, gastrostomy, et. al. (only colorectal resection, gastrostomy and hernia procedures are included).<br>• Many kidney/urinary tract procedures such as correction ureteropelvic junction, ureterectomy, ureterneocystostomy, cystostomy, bladder reconstruction (only nephrectomy and kidney transplant procedures are included).<br><br>Part of the problem with the Table 1 Planned Procedure List specifications derives from the surgical categories that Table 1 is built from. This is described further in Section III (4) of these comments, but in brief, Table 1 is built from the AHRQ Clinical Classification System which has 103 surgical categories, many very broadly defined, including 29 from residual other procedure categories. It is difficult to specify the logic for Table 1 without more discretely defined surgical categories.<br><br>In all, the Table 1 Planned Procedure List is missing many important and high volume surgical procedures. Many of these are done on a "planned" basis or are done for acute illness or trauma, but that does not make them potential preventable. As identified earlier, specific clinical logic needs to be developed, judging the relationship between surgical procedures in the index admission and readmission or based upon PDXes in the readmission, identifying that the second surgery is done as a result of complications from the first surgery.<br><br>If implemented in a complete and thorough manner, the number of short term readmissions for surgery that are potentially preventable would likely be a small subset of all short term readmissions that are potentially preventable. On the basis of the Table 1 Planned Procedure List, there will likely be many surgical readmissions falsely identified for inclusion in the HWR system. This will be compounded further by the Table 2 Discharge Condition Categories Considered Acute or Complications of Care. Diagnoses of acute illness should not cause a readmission for surgery to be considered a potentially preventable readmission, unless the judgment can be made that the acute illness is likely the result of inadequate care.<br><br>**3. <u>Inclusion/Exclusion Criteria (Section 2.3.2)</u>**<br>Seven exclusion criteria are defined. Many of these reflect the purposes of readmission measurement systems, are logical, and we support them. NACHRI does wish to offer two additional recommendations, but first a quick review of what we agree with.<br><br>We agree that patients who die should be excluded as they can no longer have a readmission. We also agree that patients transferred to another hospital or admitted for rehabilitation are planned or purposeful admissions and should be excluded. Also, patients who elect to be discharged against medical advice should not be counted as a readmission as they elected on their own to leave the hospital early.<br><br>The requirement that the patient be enrolled for 30 days past the hospital discharge date or have died during the 30-day period is also a logical requirement to implement the system.<br><br>The requirement that the patient be continuously enrolled for 12 months prior to the index hospitalization is an option available to the | | |

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| | Medicare program, but as a cautionary note it is important to identify that this is not necessarily an option for other payors. It thus may not be practical to think that a model built with this information will be applicable for all-payor applications.<br><br>Medicare patients age less than 65 years are excluded. This is based upon the rationale that "younger Medicare patients represent a distinct population with dissimilar characteristics and outcomes". We agree with this exclusion. Patients eligible for Medicare on the basis of being SSI disabled are a very different population, with different conditions, and likely different hospitalization patterns.<br><br>PPS-exempt cancer hospitals are excluded. This is based on the rationale that they care for a "unique population of patients that is challenging of compare to other hospitals". We agree with this exclusion.<br><br>In addition, we *recommend* that *PPS-exempt children's hospitals* also be *excluded*. The same rationale applies. In addition, there has been no attempt to include children's hospitals patient discharges in the database for designing and testing the proposed HWR system, and no effort to refine the HWR to reflect the patient populations served by children's hospitals.<br><br>The last exclusion is for patients with high competing mortality risk in the post discharge period. This is defined to be conditions with mortality greater than 50% in the 30-day post discharge period. In the 65+ year old Medicare population, this is mostly medical malignancy patients. It also includes one orthopedic cohort, patients who are admitted for fracture of neck of femur and do not receive a surgical procedure.<br><br>There is no question that these patients should be excluded. The quality signal would definitely be dwarfed by unavoidable severity of illness. The concern is that this exclusion is too narrow. A 50% mortality rate within 30-days of discharge is an extraordinarily high mortality rate. We have two recommendations. The *first recommendation* is an earlier recommendation to exclude broader groupings of malignancy patients from the proposed HWR system. The *second recommendation* is to lower the mortality threshold for this exclusion. Sensitivity analysis would be needed to assess more appropriate thresholds, but probably something in the range of 25% mortality would be more appropriate than 50%.<br><br>**4. <u>Definition of Index Admission Patient Cohorts (Section 2.3.1 and Appendix Tables A, B and C)</u>**<br>*Description of HWR Approach to Index Admission Patient Cohorts:*<br><br>To define index admission patient cohorts, the HMR proposal selected the AHRQ Clinical Classification System (AHRQ-CCS). The AHRQ CCS contains two levels of classification software for both diagnoses and procedures. The CCS single-level software contains general categories. The CCS multi-level software contains more specific categories. The HWR proposal chose to work from the single-level software with the more general categories.<br><br>Three reasons are given for selecting the AHRQ Clinical Classification System: "It is well know and widely used, 2) it is based on the principal diagnosis and not on complications or events that occur during hospitalization (unlike the Medicare Severity Diagnosis Related Groups [MS- | | |

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| | DRGs], and 3) because the groups of ICD-9-CM codes within each category are more clinically homogeneous than other available groupers (MS-DRGs and CMS Condition Categories) and have relatively similar readmission rates."<br><br>The proposal document elaborates a little on the first of these three reasons, but not the second or third. Regarding the first reason, it identifies that managed care plans, insurers and researchers have used the CCS for a variety of functions. It does not mention anything about hospitals using the CCS, which is of concern since the intended application is a quality measurement and public reporting tool for hospitals.<br><br>The second reason cited is that the CCS is based upon the principal diagnosis and not on complications or events that occur during hospitalization (unlike MS-DRGs). This is unclear. If the HWR proposal wished to limit the information to diagnoses present-on-admission, it could do this with any classification system by limiting the data feed to principal diagnosis and secondary diagnoses present-on-admission. Whether this provides a sufficiently complete description for the purposes of the readmission system is an issue of concern, but the CCS proposal does not need to select the CCS to avoid capturing complications or events occurring during the hospitalization.<br><br>The other part of this that is not clear is the classification of patients with surgical procedures. How were patients who had multiple procedures classified? Many patients have multiple procedures and these include some of the more complicated surgical patients.<br><br>The third reason cited is that the CCS categories are more clinically homogeneous than other available groupers, with specific reference made to the MS-DRGs and CMS Condition Categories. There is no further elaboration of this statement. There is no explanation of how clinical homogeneity was evaluated, the criteria used, findings of relative strengths and weaknesses, or how its conclusions were reached. There is also no mention of other classification systems considered. This is a serious concern.<br><br>*Detailed description of the CCS medical categories and CCS surgical categories:*<br><br>*Medical patients* are assigned to one of 285 CCS single-level categories based entirely upon principal diagnosis. Secondary diagnoses and non-O.R. procedure information are not used. These 285 CCS categories and then aggregated into six broad service line groups defined as: neurology, cardiorespiratory, cardiovascular, oncology, medicine, and psychiatry.<br><br>Many of the CCS single-level diagnoses categories are very broad. To illustrate, there are categories that contain all congenital heart anomalies ranging from the simplest to the most complex, and likewise for anomalies of the nervous system, digestive system, genitourinary system, et al. Other examples of very broad categories include: Intracranial injury includes all skull and intracranial injury and concussion diagnoses, with or without bleeding and with or without coma. Burns include all burns of all sites, 1st degree, 2nd degree, 3rd degree, and deep 3rd degree. Development Disorders includes diagnoses ranging from stuttering and learning disorders to development delay, mild mental retardation and profound retardation. Paralysis includes hemiplegia, all forms of cerebral palsy, quadriplegia, paraplegia, monoplegia and transient paralysis in limb. Coagulation and Hemorrhagic DXes includes all such diagnoses ranging from the | | |

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| | simplest to most complex.<br><br>There are also many residual "other diagnoses condition" categories that are even broader and more diverse. "Other Nutritional, Endocrine and Metabolic Disorders" includes major inborn errors of metabolism, minor dietary metabolic disorders, failure to thrive, a variety of signs and symptoms diagnoses, and V codes for body mass index from high to middle-of-the-range to low. "Other Nervous System Disorders" include sleep disorders, pain diagnoses, carpal tunnels, peripheral neuropathies, encephalopathy, muscular dystrophy, lack of coordination/ataxia, a variety of neurologic signs and symptoms, history-of V codes, and ventricular shunt status. "Other Congenital Anomalies" contains a wide range of body systems and a very wide range of conditions by severity and multiple body system involvement.<br><br>The more specific categories also often contain a wide spectrum. For example, HIV contains HIV disease and asymptomatic HIV infection. Leukemia includes acute leukemia and chronic leukemia, myeloid and lymphoid leukemia, and all DX codes whether in remission, not in remission, or in relapse. Hepatitis includes chronic and acute hepatitis, with coma and without coma. Diabetes with complications includes all codes whether chronic or acute. Acute myocardial infarct includes all DX codes whether for the initial acute episode or subsequent episode. Conduction Disorders include 1$^{st}$, 2$^{nd}$, 3$^{rd}$ degree blocks, pacemaker status, and defibrillator status.<br><br>*Surgical patients* are identified through the AHRQ CCS procedure categories. The AHRQ CCS single-level software has a total of 231 procedure categories. The HWR development team identified 103 of these categories to be for surgical procedures. All of these categories are aggregated into one very broad service line group, surgery/gynecology.<br><br>Some of the 103 surgical categories are for specifically defined surgeries, mostly high volume procedures, such as: coronary artery bypass, peripheral vascular bypass, gastrectomy, kidney transplant, bowel resection, colostomy, appendectomy, hernia repair, hip replacement, cholecystectomy, amputation of lower extremity, skin graft, nephrectomy, tonsillectomy & adenoidectomy, mastectomy, hysterectomy, and Cesarean section.<br><br>A second group of the surgical categories are for more broadly defined procedures such as incision/excision of central nervous system, heart valve procedures (open heart and percutaneous), and repair of fracture/dislocation/other disorder of hip & femur (same for lower limb and upper limb).<br><br>A third group, representing 29 of the 103 surgical categories, is for "Other Procedures" such as other upper GI procedures, other lower GI procedures, other GI procedures, other nervous system procedures, other heart procedures, other procedures of hemic and lymphatic system, et. al. These are extremely heterogeneous categories and very problematic.<br><br>To illustrate, "Other Heart Procedures" contains many of the most complex congenital heart repair as well less complex congenital heart repair, a wide assortment of open and closed heart procedures, insertion of heart assist systems, et al. Another category, "Other O.R. Procedures on Vessels Other Than Head & Neck" has more readmissions than any other surgical category, yet is extremely wide ranging and | | |

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| | diverse.<br><br>An even more fundamental question raised earlier is how patients with multiple procedures are classified. The proposal describes how individual procedures are classified. However, there is no mention of how surgical patients are classified. Are there surgical hierarchies? Are there groupings or other methods that distinguish patients who have multiple procedures? How is a full description of surgical patients provided?<br><br>*Summary of Concerns with the HWR Approach to Defining Index Admission Patient Cohorts:*<br>1. The CCS single-level categories for medical and surgical patients that are used are very broad, sometimes containing rather different conditions, and often conditions that vary greatly in their acuity or complexity. Important differences are not captured, especially for specialized medical conditions and surgical services.<br>2. It is not clear what analysis and evaluation led to the selection of the AHRQ CCS, or what consideration was given to other classification systems and methods. It is clear that on the whole, these are broad and heterogeneous categories. It is of concern that a classification system not regularly used by hospitals was selected for measurement of hospital readmissions.<br>3. The principal diagnosis (PDX) for a hospitalization does not always capture the patient's chief underlying health condition, the entire care team involved, and likelihood of future hospitalizations. For example, patients admitted for PDXes of asthma or pneumonia who have cystic fibrosis or bronchopulmonary dysplasia have very different hospitalizations and their likely future hospitalization patterns are also very different. Patients admitted for asthma, pneumonia, esophageal reflux, seizure disorder, hip & femur deformities, or scoliosis who have cerebral palsy are very different patients involving a broad based care team and are not well described by the six broad medical service lines.<br>4. There is no explanation of how surgical patients who have more than one procedure are grouped. There are many patients who receive multiple procedures, including many of the more complex surgical patients.<br><br>Does the HWR system actually group surgical patients? Or, are all the CCS surgical categories that a patient has just passed to the risk adjustment regression model?<br>5. The groupings for surgical patients do not take into account the diagnostic conditions for which the surgery is performed. ICD-9-CM procedure codes are not always very specific and using diagnosis codes together with procedure codes can help to distinguish more complex surgeries. It can also identify conditions that are more likely to require ongoing care including multiple hospitalizations.<br>6. The six medical service lines of the HWR proposal are very broad, and they do not all seem to represent a distinct team of doctors, nurses, care coordinators, pharmacists, etc. For example, asthma, pneumonia, COPD, and respiratory failure/insufficiency are grouped with congestive heart failure in a service line for Cardiorespiratory on the basis that they are clinically indistinguishable and typically treated by the same care teams. Then, cystic fibrosis and other pulmonary diagnoses are grouped with Medicine. If this is helpful for a Medicare population, the same is not true for other patient populations. | | |

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| | The service line for Medicine is extremely broad. This includes eye, ear/nose/throat, cranial-facial, pulmonary, gastrointestinal, rheumatology, dermatology, endocrinology, nephrology, gynecology, hematology and immunology, infectious disease, burn, and trauma. This involves many different conditions, practitioners, and care teams. This does not seem to be a distinct care team. As such, it is hard to see how this would be helpful?<br>7. There is one service line for all of surgical services including gynecologic services. How it is it helpful to group all surgical specialties and care teams together?<br>8. In summary, NACHRI believes the CCS categories are overly broad and heterogeneous, and recommends further exploration and testing of alternate classification methods.<br><br>**5. <u>Risk Adjustment:</u>**<br>*Introduction:* The HWR risk adjustment model is designed to produce for each of seven hospital service lines, a summary risk adjustment score by calculating the volume-weighted logarithmic average of the predicted-over-expected ratios and multiplying the result by the average national readmission rate. To do this, the HWR model provides specifications for the following five items:<br>• Data Sources and Restrictions<br>• Index Admission Patient Cohorts<br>• Comorbidities<br>• Risk Adjustment Variables<br>• Statistical Approach<br><br>Following is a brief description and critique of these five items. The framework for the critique will draw from Section II of this document, "Key Concepts and Principles for Design of Readmissions Measurement Systems," which put forward the following key components of hospital readmission risk adjustment:<br>• Reason for admission.<br>• Acuity of hospitalization, taking into account principal and secondary diagnoses and procedures.<br>• Complex and multiple chronic health conditions.<br>• Technology dependent conditions<br>• To the extent possible – family, social and psychological factors.<br><br>*Data Sources and Restrictions:* For the index admission patient cohorts, principal diagnoses (PDXes) are used along with procedure codes. Secondary diagnoses (SDXes) are not used. Please confirm that all procedure codes are used?<br><br>For comorbidities, diagnoses are used from the index admission except if viewed as potentially a complication. Diagnoses are also used from other hospitalizations during the past 12 months. Diagnoses from other settings are not used (because Medicare outpatient data is | | |

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| | technically cumbersome to work with and outpatient data is difficult to obtain from all-payer datasets). Diagnoses from the readmission hospitalization are not used, not even chronic condition diagnoses.<br><br>NACHRI believes this approach leaves out key information from current hospitalizations that is likely to be relevant to the likelihood of a readmission. NACHRI also believes the proposed approach is overly dependent on historic data that will often not be available outside of the context of Medicare.<br><br>NACHRI recommends that for index admission patient cohorts, all principal and secondary diagnoses be used except if the SDX occurs after admission and is clearly identifiable as a complication of care, and also all procedure codes.<br><br>NACHRI recommends that for comorbidities, the model focus on all principal and secondary diagnoses from the index admission (except SDXes clearly identifiable as a complication of care), plus chronic condition diagnoses (PDX or SDX) from the readmission. NACHRI also supports the use of diagnoses from the past 12 months, especially chronic conditions, but this should be offered as part of an alternate supplemental module when the data is available and the basic model should not depend on the existence of 12 months of prior hospital discharge information for every patient.<br><br>*Index Admission Patient Cohorts:* This was discussed at length in Section III (4) of this document where we expressed our concerns that the CCS medical and surgical categories are overly broad and heterogeneous, and recommended further exploration of alternate classification methods. To this we add our concern that limiting the data source to principal diagnoses is overly restrictive.<br><br>*Comorbidities:* For comorbidities, the proposal selected the use of the CMS Condition Categories (CMS-CCs), except it excluded those occurring during an index admission if it felt these could potentially represent complications. The rationale for their selection is explained by the developers as, "We used CMS-CCs, the grouper used in previous CMS risk-standardized outcomes measures, to group ICD-9-CM codes into risk adjustment variables, since four CMS condition-specific claims-based readmissions models that use this have been validated against data that use charge abstracted data for risk adjustment."<br><br>NACHRI has not previously reviewed the use of these CMS-CC categories for CMS risk adjustment models, but took a first look at these diagnosis categories to see how well they might capture diagnoses that NACHRI has observed to be important for analyses of readmissions for pediatric and all age patient populations. Following are highlights of our initial findings.<br><br>Some of the individual CMS-CCs appear to be fairly specifically defined, some are more broadly defined, and some contain a disparate set of diagnoses. The heterogeneity is probably greater for diagnoses common to younger populations but applies to a variety of CMS-CCs. For example, Renal Failure contains acute and chronic renal failure and stage I chronic renal disease through end stage renal disease. Decubitus Ulcer includes stage I though stage IV. Central Nervous System infections includes very extreme infections and much less serious infections such as viral meningitis NOS. Seizure Disorders includes complex epilepsy codes and febrile convulsions NOS. Other Development | | |

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| | Disabilities includes learning disorders, certain emotional disorders, and congenital malformation syndromes affecting multiple body systems. Other Perinatal Problems Affecting Newborns includes mild symptom codes, twin status, and some serious acute illnesses. Serious Perinatal Problem Affecting Newborns includes a wide range of perinatal codes and also some very serious congenital anomalies.<br><br>A subset of the CMS-CCs was selected to be included among those used for the final risk-adjustment variables. These were then further aggregated into 15 CC groupings. The CCs selected appear to be conditions more common amongst elderly patients. Many conditions important for younger and all age populations were not included. There were also not any technology dependent categories included.<br><br>Also of concern is the aggregation of CCs that vary widely in their complexity. For example, schizophrenia, depression NEC, and other psychiatric disorders (mostly mild chronic or acute diagnoses or symptoms) were aggregated together. Infectious CCs were aggregated together that range from HIV, to a range of different central nervous system infections, serious opportunistic infections, and other infectious disease which includes viral enteritis. Diabetes with acute complications was aggregated with diabetes with chronic disease manifestations.<br><br>In sum, NACHRI has many questions and concerns about the CMS-CCs and how they are used in the proposed HWR system. NACHRI is especially concerned about the number of serious chronic conditions not included, the number of less serious and acute conditions that were included, the aggregations of conditions that vary greatly in their complexity, and the absence of technology dependent condition categories.<br><br>*Risk Adjustment Variables:* The HWR system includes the following variables in its regression methodology: age, index admission patient cohort (CCS), and comorbidities (CMS-CC). The proposal does not use socioeconomic status, gender, race, or ethnicity. The proposal also does not use admission source or discharge disposition.<br><br>Overall, NACHRI has a number of concerns about the adequacy of this approach. Most of the specific concerns have already been identified but to summarize very briefly:<br>• Reason for admission is not adequately described.<br>• Acuity of hospitalization is not adequately captured. Secondary diagnoses from the index admission are not even considered.<br>• Comorbidities are not fully reflected for complex and multiple chronic conditions.<br>• Technology dependent conditions are not provided for.<br>• Family, social and psychological factors are not considered except for one aggregated comorbidity grouping of psychological diagnoses.<br><br>*Statistical Approach:* The one-week-to-respond time frame did not allow for close inspection of the statistical model but NACHRI has a concern with the overall approach as a complex statistical model rather than a clinical model. | | |

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| | It seems to be difficult to know what is driving the model, and the model will require ongoing recalibration for each database it is run on. In addition to rerunning all of the statistical algorithms, it seems that it would be necessary to respecify the diagnosis and procedure categories to capture conditions important to each population group.<br><br>NACHRI recommends the development of a more robust clinical model, and less dependence on statistical models. This will be easier for users to work from, and will yield more discrete and actionable clinical information for the user.<br><br>**6. <u>Testing and Evaluation</u>**<br>The HWR proposal document in Methods Overview Section 2.1 references evaluating the performance of the measure for various types of hospitals and groups of patients, but this is not presented, so we are unable to offer specific comments.<br><br>The proposal indicates that it plans to test the reliability of the proposed measure by randomly splitting the combined 2007 and 2008 data and comparing performance in each split sample. We are not clear as to exactly what will be tested, and what this is likely to demonstrate. It seems that the two random samples of 4,000,000 index hospitalizations will likely show similar patterns as the full dataset of 8,000,000 index hospitalizations. Additionally, it seems concerning that some of the same data used to develop the model will be used to test the model if we are interpreting the report correctly.<br><br>The proposal also indicates it will be testing the measure's stability over time by comparing 2008 and 2009 performance. We're also unclear what this will demonstrate.<br><br>NACHRI *recommends* that evaluation and testing occur at three levels.<br>(1) For statistical testing and validation, NACHRI recommends that emphasis be given to testing readmission patterns for biased subgroups of patients and hospitals.<br>(2) For case level testing from UB-04 discharge abstract data, NACHRI *recommends* that case level information be generated and evaluated to identify what kinds of cases being excluded and included (are these as intended?); and, whether these cases appear to represent readmissions that the hospital could likely have prevented.<br>(3) For case level validation from medical chart level information, NACHRI *recommends* testing be conducted to verify whether the exclusions and inclusions are truly identifying the intended populations; and, to verify that the readmissions do actually involve situations that the hospital could likely have prevented. | | |
| 8/29/2011 | University HealthSystem Consortium (UHC) appreciates the opportunity to comment on CMS' draft Measure Methodology Report for the Hospital-Wide (All-Condition) 3D-Day Risk-Standardized Readmission Measure (the "Readmission Measure"). As you may be aware, UHC is a member-owned alliance of 113 academic medical centers (AMCs) that has a 25-year history of comparative data analysis for the purposes of performance improvement. These data include performance information on quality, safety, and efficiency of both AMC hospital care and the outpatient practice of faculty physicians. Connected with these activities is an active performance improvement program that seeks to discover and describe efforts to | Roberta G. Graham<br>Executive Vice President<br>University HealthSystem Consortium | Hospital/ health system |

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| | improve quality, safety, and efficiency that have borne fruit in the AMC environment.<br><br>As you may also be aware, UHC has conducted research on readmission rates and the causes for readmission. As part of its research, UHC has devised methodologies that it uses in its research. Given UHC's interest and experience in the area of readmission research, UHC welcomes the opportunity to review CMS' methodology and provide comments. UHC reviewed the methodology report and agrees with many of the approaches to the methodology. UHC also believes that certain areas of the methodology can be improved upon. What follows is UHC's assessment of the Readmission Measure.<br><br>Section 2.2 Outcome Definitions and Section 2.3 Definition of Eligible Population<br>Overall, UHC agrees with the definitions contained in the Readmission Measure. Specifically, UHC agrees with: (i) the choice of planned procedures as a method to affirm the need for multiple admissions to meet a standard of care in some instances; (ii) the explanation of planned versus unplanned procedures; (iii) the selection of all-cause readmission as an overall metric for evaluation; (iv) using a 3~-day timeframe, both from a standpOint of appropriateness of care as well as consistency with other commonly used readmission metrics; (v) excluding patients who leave against medical advice, are transferred out to another acute care hospital, and discharges with a high postdischarge mortality; (vi) counting each individual admission within 30 days versus methods that consider any activity within 30 days, regardless of the number of admissions (in UHC's opinion, assessing on an individual admission basis allows for differentiation in care quality between a hospital that readmits a patient once for a given condition, versus another hospital that may have to readmit the patient 3 to 4 times in the same time period); and (vii) using Condition Classification System ("CCS") groups to define planned procedures and discharge condition categories (in UHC's opinion, using this methodology, as opposed to MS-DRGs, makes clinical sense. Further, using the CCS allows the methodology to extend to other care settings, such as ambulatory care, where MS-DRGs are not utilized.)<br><br>Although UHC agrees with the basic text of the definitions, there are areas that the definitions do not capture or address. UHC believes that further clarification on the following issues would create a more definitive measure and enhance the quality of the data:<br><br>• **Differentiating Planned Readmissions.**<br>While UHC supports the concept of planned admissions, the proposed Readmission Measure does not define how it will evaluate or categorize admissions that do not fit within the proposed definition of planned admissions and are also not acute or admissions for complications of care. In the UHC methodology, UHC has found for example, that a patient who is admitted with a primary diagnoses of renal dialysis, the index admission, with no associated procedure, will then retum for either a diagnosis or a primary procedure of dialysis. In this case, the planned readmission may be defined with either a diagnosis or a procedure code. This admission is not addressed in the proposed planned procedures list and is not considered acute. UHC believes that additional parameters are needed to further differentiate these types of admissions.<br><br>• **The Application Of CCS Groupings Appears Contradictory.**<br>It is unclear whether an acute or complication case is determined when the discharge condition category is only the principal diagnosis, or if the | | |

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| | presence of one of these conditions anywhere in the inpatient record constitutes an acute or complication case. By way of example, the Overview on page 9 of the Readmission Measure states: 'We used the Agency for Healthcare Research and Quality (AHRQ) Condition Classification System (CCS) to group hospitalizations into clinically-coherent, mutually-exclusive condition categories according to their principal diagnosis." Notwithstanding this statement, Table 2 "Discharge Condition Categories Considered Acute or Complications Of Care" on page 13 of the Readmission Measure states: "when a discharge condition category contained a mix of acute and chronic diagnoses (implying that the diagnosis can be anywhere in the patient record), it was categorized as acute." Accordingly, for hospitals that treat particularly complex patients, applying these groupings to principal diagnoses only as opposed to using any diagnosis contained within the medical record, will Significantly impact the numerator used to calculate readmission rates. By way of example; in one year's worth of inpatient discharges from UHC's clinical database among AMCs there were 55,842 inpatient discharges with a principal diagnosis of septicemia per the CCS diagnosis definition. If the definition of discharges involving acute conditions or complications of care were expanded to include cases with this diagnosis group as the principal or secondary diagnosis, the number of inpatient discharge affected increases to 149,158, or 2.67 times the principal diagnosis-only condition.<br><br>**• The Application Of Present On Admission (POA) Indicators On Discharge Condition Categories.**<br>UHC believes that the Readmission Measure should further elucidate how the POA indicators will be utilized. UHC is concerned that without specific parameters for the application of POA indicators, variance in interpretation between conditions that are Present on Admission and those conditions that develop during the course of treatment (possible complication), specifically when the procedure of the readmission falls on the planned procedure list, will result in inconsistent data collection. (E.g., if a patient returns for a spinal fusion [on the list of planned procedures] and also has a urinary tract infection [on the list of acute/complication conditions] is the present evaluation method adequate in that is differentiates whether or the UTI is acquired in the hospital or present on admission?)<br><br>• Evaluation Of Patients That Transfer Between Units Of The Same Hospital.<br>While the Readmission Measure adequately defines treatment of transfers to other acute care hospitals, the treatment of transfers within a hospital is not clearly defined. In certain instances, reimbursement regulations result in two discharge records being generated when a patient is transferred from one inpatient unit to another inpatient unit within the same hospital. (E.g., a transfer from a general medical/surgical unit to a psychiatric unit; this transfer is part of the continuum of care for that patient, not a readmission of the type that is sought in this methodology.)<br><br>• Timeframe For Readmission.<br>UHC requests further definition of the timeframe after which a patient is discharged and returns for admission in order for the same-day admissions to be considered a readmission as opposed to a continuum of care. (E.g., how does the Readmission Measure intend to address the situation when a patient is discharged from an inpatient admission and then returns and is readmitted within 24 hours or on the same calendar day?)<br><br>• The Exemption Of PPS-exempt Cancer Hospitals From The Calculation.<br>UHC believes that the Readmission Measure should not exempt PPS-exempt cancer hospitals. In UHC's experience, PPS-exempt cancer hospitals in UHC's membership believe that comparisons to other cancer centers are key to examining performance improvement efforts, regardless of | | |

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| | reimbursement methodology. With the creation of a cancer model group as noted in Table 3 of the Readmission Measure, it would appear that cancer patients are an area of interest to CMS and the use of CCS removes the requirements for hospitals to report on a MS-DRG basis, which eases reporting by some PPS-exempt facilities. UHC believes that this exclusion should be reconsidered in order to provide a comprehensive and accurate portrayal of cancer patient care readmissions.<br><br>Section 2.4 Administrative Model Development, Section 2.5 Administrative Model<br>Development and Section 2.6 Statistical Approach to Model Development<br>For the purpose of modeling, UHC agrees with the use of administrative data for fee-for-service Medicare beneficiaries. UHC utilizes administrative data for its risk models for mortality, length of stay and direct cost. This being said, UHC is concerned with the limited number of 9 diagnosis codes available in the Medicare Provider Analysis and Review (MEDPAR) file. UHC accepts up to 99 diagnosis codes and 99 procedure codes per patient encounter. The more acute patients in the UHC database, classified by risk of mortality, average 19 diagnoses and for 69% of UHC's AMCs, the mean number of diagnoses per case is over 9. By way of example, looking at the final riskadjustment variable for ulcers (rf30), only 41% of patients in the UHC database would be captured. Over half of the AMCs' patients would not get credit for this condition as the diagnosis code is after the ninth position. With severe cancer ( rf4), only 77% of the AMC's patients who had the appropriate ICD-9 would get the variable credit since the diagnosis is beyond the 9th position. In the modeling process the appropriate strength of the variable may not be calculated accurately due to limiting the diagnosis to 9 as some of the most acute patients who, due to their medical co-morbidities, require more diagnosis codes to properly reflect their acuity level. These patients at higher risk for readmission are not factored properly in the calculation. Additionally, AHRQ accepts up to 30 diagnosis codes per encounter in measuring its Patient Safety Measures (PSis). CMS has announced that it is planning on expanding acceptance of codes to 25 to better utilize administrative data. UHC urges CMS to expand the analysis beyond the 9 diagnosis codes and also when evaluating a hospital's performance allow at least 25 codes for consideration.<br><br>UHC appreciates the difficulty in utilizing outpatient data and appreciates the 12-month retrospective review prior to the index admission for co-morbidities, but this approach fails to capture many conditions that are POA in the index admission, but were present prior to the admission and noted in outpatient visits. UHC proposes that the methodology use the POA code to help assess comorbidities as opposed to complications. A well-managed patient may not have any prior admissions to the index admission but some of the more significant risk variables would only be known using POA indicators.<br><br>UHC applauds the use of multiple models that would provide better discrimination and predicative ability for readmission risk. However, UHC is concerned that there are still too few models leaving heterogeneous patients grouped together. The surgical/gynecological cohort is a very broad group of surgical subspecialties and gynecology. The overarching rationale of groupings was " ... in part related to the care provided by a team of doctors, nurses, care coordinators, pharmacists, etc." In general, surgical patients are cared for by a different team than gynecological patients. This dichotomy is borne out by the fact that many hospitals have specialized women's centers, frequently housed outside of the general hospital building. UHC believes that combining surgical and gynecological populations will make it more difficult to focus improvement opportunities based on the | | |

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| | results. Accordingly, UHC suggests subdividing the remaining surgical cases to better match the subspecialties as again they are managed in general by different teams and as a whole are a very heterogeneous population. Furthermore, a problem with one subspecialty area may overshadow excellence in the other areas or a problem in a subspecialty area may remain hidden by excellent performance overall for the cohort.<br><br>UHC also believes that heart failure patients are very different from patients with pneumonia and chronic obstructive pulmonary disease and would be better suited in the cardiovascular cohort.<br>Additionally, patients with congestive heart failure tend to be treated more commonly by the same team as patients with other cardiovascular conditions.<br><br>UHC agrees with the final risk variables used but believes that the admission source, especially transfer from another acute care hospital, should be an independent variable. Although the final discharge disposition is done by the receiving hospital, the patient often lives further from the receiving hospital and the majority of care that the patient has received has been from the transferring hospital. The patient is likely to return to the transferring hospital to receive follow-up care despite the arrangements from the receiving hospital. This reality places the receiving hospital at a disadvantage in its effort to maximize outpatient arrangements to prevent readmission. AMCs are at a high disadvantage as they receive the majority of transfers and accept all the risk and many of these AMCs are Safety Net facilities.<br><br>The reliability of the overall models also troubles UHC. Specifically, the C-statistic for the models is between 0.605-0.676. For the UHC models, the C-statistic models must be greater than 0.70 and in practice, most UHC C-models have a C-statistic over 0.80. A C-statistic of 0.605 means the model properly predicts 60.5% of the time. It implies that the model is missing critical factors for predicting risk of readmission. UHC believes that the proposed C-statistic model can be improved by expanding the number of diagnosis codes evaluated or expanding the number of models to more homogeneous groups which should improve the C-statistic.<br><br>Last, UHC understands that a providing a single weighted score to a hospital is desirable, however,<br>UHC questions the utility of a single score. UHC believes that publically reporting a single weighted score for each hospital is an unfair assessment. UHC can foresee the situation where a hospital may have a problem in only one area and the single score may penalize the hospital overall. From the hospital standpoint it is most helpful to have a smaller focus, as process improvement is most successful if focused on a target population first.<br><br>The AMC members of UHC support CMS' Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Measure. UHC and its AMCs have been conducting research on readmissions in an effort to improve patient care, reduce readmissions and make UHC's AMCs leaders in quality care and cost effectiveness. UHC appreciates the opportunity to respond to CMS' request for comments of the Readmission Measure and looks forward to working with CMS on this important undertaking. | | |