



## Appendix 13-B: Public Comments Summary

**Project Name:**

Hospital-Level Measures of Risk-Adjusted 30-Day Episode-of-Care Payments for Heart Failure (HF) and Pneumonia

**Date of Report:**

September 27, 2013

**Contractor (Measure Developer) Name(s):**

Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE)

**I. Introduction**

The measure developer YNHHSC/CORE prepared this summary. We consulted with the Centers for Medicare & Medicaid Services (CMS) in its preparation.

**Dates of public comment period:**

Tuesday, August 6, 2013 through Friday, September 13, 2013

**Website used:**

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html>

**Methods used to notify stakeholders and general public of comment period:**

- Email notification to CMS listserv groups
- Email notification to relevant stakeholders and stakeholder organizations, including:
  - Medical associations and societies: American Association for Bronchology and Interventional Pulmonology, American Association of Cardiovascular and Pulmonary Rehabilitation, American Association for Respiratory Care, American Association of Cardiovascular and Pulmonary Rehabilitation, American College of Cardiology, American College of Chest Physicians, American Geriatric Society, America's Health Insurance Plans, American Heart Association, American Hospital Association, American Lung Association, American Thoracic Society, Association of Pulmonary & Critical Care Medicine Program, COPD Foundation, COPD Clinical Research Network, National Association for Medical Direction of Respiratory Care, National Heart Lung and Blood Institute, Pulmonary Education and Research Foundation, and the Respiratory Nursing Society

- Health economics associations: The Brookings Institute, Health Care Cost Institute, and The Urban Institute
- Consumer associations: American Association of Retired Persons, Consumers Union, Childbirth Connection, Community Alliances, and the National Partnership for Women and Children
- Email notification to Technical Expert Panel members
- Posting on CMS Public Comment website

## Volume of responses received:

We received four comment letters in total, from Intermountain Healthcare, University Hospitals, the American Hospital Association, and the National Partnership for Women & Families. Within these four comment letters there were 14 comments on the following six topics: cohort; transfer/episode attribution; calculating the payment outcome; risk adjustment; implementation/use; and general support.

## II. Stakeholder Comments—General

### Summary of general comments and responses:

#### 1. Cohort

##### *1.1. Identification of HF and Pneumonia Patients*

- One commenter stated that the cohort was well defined and appeared consistent with the CMS inpatient core measures.

**Response:** CMS appreciates the support for this aspect of the measure. To clarify, the HF and pneumonia core measures are process measures, while the HF and pneumonia payment measures are measures of payments for Medicare patients. The cohort in the HF and pneumonia payment measures mirrors that of CMS's 30-day HF and pneumonia mortality measures, with which the HF and pneumonia payment measures are aligned.

##### *1.2. Inclusions/Exclusions*

- One commenter recommended that patients with a history of receiving a heart transplant and left ventricular assist device (LVAD) within at least the last 12 months should be excluded from the measure. Another commenter recommended risk adjusting for heart transplant and LVAD patients.

**Response:** The HF payment measure excludes index admissions for patients who underwent a heart transplant or received an LVAD during the index hospitalization or 30-day episode of care. The measure does not exclude index admissions for patients with a history of heart transplant or LVAD. The goal in developing outcomes measures is to create a clinically cohesive cohort that includes as many patients as possible admitted with the given condition. Greatly expanding our list of exclusions would result in a measure that was less useful and meaningful, because it would reflect the care of fewer patients and diverse clinical conditions. However, during measure maintenance, a process whereby we update and revisit key decisions, we will evaluate the possibility of risk adjusting for patients with a history of heart transplant or LVAD.

- One commenter supported excluding patients who received a heart transplant or LVAD during the episode of care.

**Response:** CMS appreciates the support for this aspect of the measure.

- One commenter noted that they understand the need to exclude subsets of patients who are particularly expensive and not representative of the target population, but the commenter urged CMS to avoid unnecessary exclusions that may remove variation and ultimately lose potential opportunities for improvement.

**Response:** The goal in developing these measures is to create a clinically cohesive cohort that includes as many patients as possible admitted with the given condition. The majority of the exclusions mirror that of CMS's 30-day HF and pneumonia mortality measures in order to align the measures. However, for the HF payment measure we exclude index admissions for patients receiving a heart transplant or LVAD during the index hospitalization or episode of care because they are clinically distinct, generally very high payment cases, and not representative of the typical heart failure patient that the measure aims to capture. We did not make any similar exclusions for the pneumonia payment measure. However, we revisit the measure cohorts every year during measure maintenance.

## 2. Transfer/Episode Attribution and Episode Definition

- One commenter stated that while one organization should be accountable for the episode-of-care payment measures, acute-care hospitals are not always that entity. The measure should instead be assigned to an entity that can exercise a reasonable level of control. The commenter stated that costs within a 30-day episode of care cannot be attributed solely to hospitals. Instead, the commenter recommended CMS pilot test the measures with organizations that are actively engaged in bundled payments programs like those participating in CMMI's Bundled Payments for Care Improvement (BPCI) initiative.

**Response:** The measure is designed to illuminate variation in payments for care during an episode that begins with hospitalization. Hospitals are not able to control all the costs of care across the episode but can play an important role in influencing the measure's results. The hospital is responsible for the care decisions made during the hospitalization as well as discharge planning. Decisions made at the admitting hospital affect payments for care in the immediate post-discharge period. Hospitals are also well positioned to collaborate and coordinate with community partners to influence patients' outcomes and trajectories. The measure is meant to be interpreted only in the context of quality outcome measures because alignment with quality measures allows for an assessment of value, whereas lower or higher payment cannot be interpreted as better or worse care in isolation. A hospital-based measure is therefore a good starting place for such measurement because of the range of accepted and

utilized quality measures that can be paired with the payment measure. CMS will look for opportunities to profile cost and value at other levels of the health system as well.

- One commenter stated transfer patients should be excluded from the measures. Another commenter worried that assigning payments to the first admitting hospital may improperly incentivize healthcare providers to avoid transferring patients because of a lack of clinical and financial control once a patient leaves their facility.

**Response:** Very few patients are transferred during the index admission for either HF (0.8%) or pneumonia (0.4%). CMS assigns the outcome for the episode of care to the first admitting hospital because the first hospital initiates patient management and is responsible for any decision to transfer the patient. CMS intends for this approach to encourage coordination between hospitals and their referral networks. This attribution strategy avoids incentivizing hospitals to transfer patients who are critically ill and at high risk of being very expensive to treat and aligns with CMS's 30-day HF and pneumonia mortality measures. CMS is committed to monitoring the measures and assessing unintended consequences over time, such as hospitals reducing the number of transfer patients in order to retain financial control over the patient's episode of care.

### 3. Calculating the Payment Outcome

- One commenter expressed concern that they will be unable to replicate their measure results and thus will not be able to validate the data.

**Response:** Hospitals will not be able to replicate their risk-standardized payment (RSP) independently. While hospitals have access to the inclusion/exclusion criteria and risk adjustment coefficients used, the model requires input of patient longitudinal data across care settings and data from the entire national sample to estimate the hospital-specific effects used in the equations.

However, hospitals will be able to validate the cohort included in their payment measures once the measures are publicly reported by using the discharge-level information contained in their hospital-specific report.

To be transparent in how the RSPs are calculated, CMS will make the measure calculation methodology (including the condition category algorithm) available once the measures are publicly reported. Hospitals will also be able to request a copy of the SAS software used to estimate the RSPs.

#### 4. Risk Adjustment

- One commenter requested the measures adjust for patients' socioeconomic status (SES).

**Response:** Because hospitals should not be held to different standards of care based on the demographics of their patients, the measures do not adjust for SES, gender, race, or ethnicity. Variation in payments associated with these characteristics may be indicative of disparities in the quality of the care provided to vulnerable populations and adjusting for these factors would obscure these disparities. This approach is consistent with NQF guidelines (see Measure Evaluation Criteria from 2012 at [http://www.qualityforum.org/docs/measure\\_evaluation\\_criteria.aspx](http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx)).

The measure developers have also performed in-house analyses which show that there is very little variation in risk-standardized payments between hospitals with different percentages of dual-eligible patients.

- One commenter encouraged CMS to maintain its general approach to inclusivity with risk adjustment and continue excluding variables related to disparities in the risk-adjustment model.

**Response:** CMS appreciates the support for this aspect of the measures.

- One commenter stated the measures should adequately account for differences in patient populations such as severity of illness and complexity of care provided in the risk adjustment

**Response:** The measures do not include risk-adjustment variables that represent clinical severity. However, when CMS developed the HF and pneumonia mortality and readmission measures we had nationally representative medical record-abstracted Medicare patient data. We demonstrated that the profiling of the hospital is very similar using both administrative and medical record data that included clinical severity.

- One commenter worried that the proposed risk adjustment model compresses results and makes it difficult to discriminate meaningful variation in performance.

**Response:** CMS has chosen to classify hospitals as outliers only when there is a high degree of certainty. To fall in the higher than national average payment category, the 95% interval estimate surrounding the hospital's RSP must be higher than the national average payment amount; the lower than national average payment category includes hospitals with 95% interval estimates lower than the national average payment amount. The point estimate is also available for each hospital and shows a range of performance across hospitals. CMS believes this approach will best provide accurate information to consumers while promoting quality improvement.

## 5. Implementation/Use

- One commenter supported considering the appropriate pairing of the HF and pneumonia payment measures with a clinical outcome.

**Response:** CMS is actively pursuing analytic methods to evaluate value by interpreting the HF and pneumonia payment measures in the context of other quality measures and welcomes suggestions.

## 6. General Support

- One commenter applauded CMS for filling two important measure gaps. The commenter believes the development and implementation of these measures will enable a move towards a system that rewards value based on high-quality and low costs.

**Response:** CMS appreciates support for this aspect of the measure.

### Proposed action(s):

The measure developers reviewed all comments carefully and discussed the most commonly raised issues. The measure developers did not make changes to any of the current measure specifications based on the public comments received. In those cases where comments indicated a need for greater clarification we will provide additional details in the final measure technical report. This report will be sent to CMS and will be available at the time of NQF consideration of the measure.

### III. Measure-Specific Comment Summaries

This section was addressed above by indicating to which aspect of the measure each comment referred. Please see above for responses to all public comments.

### IV. Preliminary Recommendations

The measure developers are not recommending any changes to the measure specifications in response to public comments. In many cases measure decisions around things such as the included cohort are reflective of the plan to closely align this measure with CMS's 30-day HF mortality and pneumonia measures for purposes of profiling hospital value.

### V. Overall Analysis of the Comments and Recommendations to CMS

CMS appreciates the public's comments. At this time CMS is not recommending any changes to the measure but will take the comments into consideration during the annual measure maintenance process and other future work.