June 13, 2017

THE AMERICAN HEALTH QUALITY ASSOCIATION

7918 Jones Branch Drive
Suite 300
McLean, VA
www.ahqa.org

Ms. Seema Verma
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma,

Thank you for the opportunity to comment on the proposed rules for Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices.

Our organization, the American Health Quality Association (AHQA), represents the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) and their quality improvement partners throughout the United States, Puerto Rico, the Virgin Islands, and the outer Pacific islands. Our association's goal is to make health care better, safer, and available at a lower cost.

As Medicare-funded organizations charged with working with providers, beneficiaries, families, and stakeholders to improve quality for our nation's Medicare beneficiaries, QIN-QIOs are keenly interested in the provisions of the proposed rule.

Below are our comments regarding selected elements included in the NPRM:

Accounting for Social Risk Factors in the Hospital Readmission Reduction Program

We applaud CMS' efforts in considering strategies to account for social risk factors in the Hospital Readmission Reduction Program. We encourage CMS to develop and implement quality incentive payments for hospitals participating that directly reward and support better outcomes for beneficiaries with social risk factors. We feel that CMS should develop and implement additional targeted financial incentives to reward achievement or improvement specifically for beneficiaries at risk because of social risk factors. These incentives would effectively support hospitals working to achieve the highest value possible for socially at-risk

beneficiaries. To ensure the incentive and reward payments are being used optimally, AHQA asks CMS to consider a requirement for low-performing hospitals that disproportionately serve a high percentage of socially at-risk beneficiaries, but fall into the lowest performance quartile, to work with the QIN-QIO on a performance improvement plan for the relevant payment program.

Although several strategies have been proposed to account for social risk factors in Medicare payment programs, we advocate for a strategy that rewards better outcomes and improvements in outcomes for socially at-risk beneficiaries that achieves an appropriate balance of accountability and fairness. It would incentivize providers to 1) serve socially vulnerable communities, 2) pursue higher quality care for beneficiaries with social risk factors, and 3) be accountable for the quality of care provided. This could be done by providing payment adjustments to reward achievement or improvement of outcomes in beneficiaries with social risk factors. The impact of this strategy on the financial status of safety-net hospitals and hospitals caring for a disproportionate share of socially-vulnerable beneficiaries should be monitored closely by CMS for both beneficial impact and unintended negative consequences.

Several social risk factors have been identified and many of them still require additional research and the development of additional health information infrastructure. Dual eligibility has been proposed as a readily available surrogate marker for social risk factors and could be used in an early implementation of our recommended strategy. We recommend, however, that CMS continue its research into social risk factors that most effectively define the socially-vulnerable beneficiary.

To optimize the impact of the payment strategy proposed above, we strongly recommend a tactic by which low-performing hospitals providing care to a disproportionate share of socially-vulnerable beneficiaries are required to work with existing quality-improvement programs: the QIN-QIO program. A mandatory standard of participation should be developed that results in an impactful scope of performance work supported by the resources in one or both of these currently-available programs. We recommend required participation for the hospitals in the lowest quartile of performance with a disproportionate share of socially-vulnerable beneficiaries (as defined by CMS).

We feel that reward for high quality, incentives to improve, and mandatory participation by low performers in Medicare quality-improvement programs is a strategy that holds providers accountable yet supports their efforts, in resource-scarce environments, to improve the quality of care for socially-vulnerable Medicare beneficiaries.

Lastly, we ask CMS to also consider the ability of the hospital electronic health record (EHR) product to capture the necessary data fields for social risk factors. Hospitals will likely need to make what could be costly modifications to their EHR systems to capture these new fields. We

recommend that CMS consider financial support to assist hospitals with product updates and development. Without the capacity to update the EHRs, the data will not represent all hospitals.

Removal of the PSI 90 from the Hospital VBP Program

As PSI 90 has already been challenging in relation to measurement and scoring for hospitals, we would support the proposal to remove the current PSI 90 measure from the Hospital VBP Program in FY 2019.

We prioritize patient safety and avoiding adverse events, however, we recognize that with the current status of PSI 90, calculating scores in a hospital setting as part of the VBP score pose significant challenges. We are confident that hospitals will stay abreast with PSI 90 composite measurement as it remains a part of Inpatient Quality Reporting (IQR). This year, IQR's PSI 90 composite score has moved to utilization of version 6.0. VBP's PSI 90 composite measurement currently uses version 5.0 (different versions have different measures).

In addition, we support the proposal of adding the composite PSI 90 back to VBP FY 2023 as it is a vital measurement, but highly recommend having the composite measurement and scoring match the PSI 90 description of IQR for FY 2023. This would improve efficiency, compliance, and ultimately safety in the hospital environment.

Refining the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)

We support the proposal to update the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure by replacing the three existing questions about Pain Management with three new questions that address Communication About Pain During the Hospital Stay, beginning with the FY 2020 payment determination.

We agree that acute pain is common and often undertreated in hospitalized patients. Although there is no clear empirical evidence linking a failure to prescribe opioids to lower hospital HCAHPS scores, the concerns and confusion surrounding the Pain Management Survey items warrant their withdrawal from the CMS strategy to assess the hospital patient experience of care. The substitute focus on communication about pain highlights the ongoing need for clinicians to assess pain, discuss pain treatment with their patients, and use shared decision-making to develop treatment plans to mitigate pain. The three proposed questions do not unduly focus on medication therapy for the management of pain and allow for considerable clinician discretion on the use of integrative therapies, physical modalities, and non-drug therapies, as well as medication-based treatments. We encourage CMS to ensure its field testing of the test items and composite measure accurately measure the domain and

encourage CMS to pursue endorsement for the revised HCAHPS Survey by the National Quality Forum.

Policy Modification for eCQM Validation for the FY 2020 Payment Determination and Subsequent Years

We support the proposal of adding additional exclusion criteria to the hospital and case selection process for eCQM validation. Along with the previous exclusions of any hospital selected for chart abstracted measure validation, and any hospital that has been granted a Hospital IQR Program Extraordinary Circumstances Exemption for the applicable eCQM reporting period, we fully agree and support the additional exclusion of adding any hospital that does not have at least five discharges for at least one reported eCQM.

We also fully support adding the proposed exclusions for case selections excluding episodes of care that are longer than 120 days, and cases with a zero denominator for each measure, which would decrease hospital reporting burden.

Lastly, we would urge CMS to consider reducing the number of cases selected for validation each quarter from 8 to a lower number in order to minimize reporting burden for hospitals.

ASC and CAH Requirement to Implement 2015 Edition Technology Upgrade

Although we fully support meaningful use of the electronic health record (EHR), we request additional clarification and information regarding the proposal that requires all Ambulatory Surgical Centers (ASC) and Critical Access Hospitals (CAH) to upgrade to a minimum 2015 EHR certified technology. Specifically we would request that information be provided as to whether or not additional funding and resources will be made available to make this technology upgrade.

Thank you for the opportunity to comment on the above proposed rules. We believe our observations, comments, and recommendations are aligned with and in support of CMS, as well as the long history and demonstrated successes of the QIN-QIOS in partnering with CMS to achieve substantive improvement in health care quality.

Regards,

Alison Teitelbaum, MS, MPH, CAE
Executive Director