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All-Cause Admissions and Readmissions, Spring 2021 Cycle: Public and Member Comments

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Measure-Specific Comments on All-Cause Admissions and Readmissions Spring 2021 Submissions

NQF #2880 Excess days in acute care (EDAC) after hospitalization for heart failure (HF), Comment #1

Standing Committee Recommendation: Recommended for Endorsement

Comment ID#: 7785

Commenter: John Barnes, Heart Failure Society of America

Council / Public: Public

Comment Period: Post-Evaluation Commenting Period

Date Comment was Submitted: September 17, 2021

Developer Response Required? Yes ☒ No ☐

Level of Support: N/A

Theme: N/A

Comment

On behalf of the Heart Failure Society of America (HFSA), we are writing to provide comments on the Excess Days in Acute Care After Hospitalization for Heart Failure measure (#2880) currently under consideration by the NQF's All-Cause Admissions and Readmissions Committee. HFSA is a multidisciplinary organization working to improve and expand heart failure care through collaboration, education, research, innovation, and advocacy. Its vision is to significantly reduce the burden of heart failure.

HFSA is concerned about this measure since our members see heart failure patients discharged too early from acute care, when their blood pressure is still unstable or their fluid overload is far from resolved. In addition, hospitals already carry the financial burden of length of stay and this would only add another burden.

Developer Response:

Thank you for your feedback. The intent of this measure is to capture the very outcome that you state that members see, by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: 1) emergency department (ED) visits, 2) observation stays, and 3) unplanned readmissions at any time during the 30 days post-discharge.

While increased LOS could be one response to this measure (i.e. hospitals appropriately do not discharge patients before they are clinically stable, so they are not readmitted, go to the ED, or experience an observation stay), ideally this measure incentivizes care transitions so that patients with HF receive adequate follow-up and post-discharge ambulatory care to reduce the risk of a post-discharge hospital visit.

NQF Response: Not applicable.

NQF Committee Response:

Thank you for your comment. The Standing Committee considered the unintended consequences of the measure and acknowledges the need to assess the potential for unintended consequences.

We appreciate the demands on health care systems and the challenge in getting care right for our patients with heart failure. The Standing Committee further recommends that the developer and CMS continue to monitor the measure for unintended consequences as results of its use.

NQF #3612 Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System, Comment #2
Standing Committee Recommendation: Recommended for Endorsement

Comment ID#: 7786

Commenter: John Barnes, Heart Failure Society of America

Council / Public: Public

Comment Period: Post-Evaluation Commenting Period

Date Comment was Submitted: September 17, 2021

Developer Response Required? Yes ☒ No ☐

Level of Support: N/A

Theme: N/A

Comment
On behalf of the Heart Failure Society of America (HFSA), we are writing to provide comments on the Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under MIPS measure (#3612) currently under consideration by the NQF's All-Cause Admissions and Readmissions Committee. HFSA is a multidisciplinary organization working to improve and expand heart failure care through collaboration, education, research, innovation, and advocacy. Its vision is to significantly reduce the burden of heart failure.

HFSA agrees with the measure steward that hospitalizations put patients at risk of exposure to adverse events, and we recognize the importance of continuity of follow-up post-discharge. However, we have significant concerns about assigning hospitalization rates per capita to a single clinician (or even clinician groups), particularly when our current health care system is increasingly team-based. As such, we do not believe this measure is appropriate for a physician-level accountability program like MIPS. We urge the NQF the abstain from endorsing this measure for use under MIPS and will similarly urge CMS not to finalize its recent proposal to adopt this measure for use under MIPS starting in 2022. A more appropriate strategy for measurement of this patient population, particularly in a pay-for-performance program, would be to focus on actions that are in the direct control of the physician or else to use this type of measure for facility or system-level accountability (e.g., ACOs, the VA, etc.).

HFSA also believes that metrics that count hospitalizations are misguided in that they focus purely on utilization, without regard to quality, and create perverse incentives by rewarding clinicians who up-code, avoid certain high-risk patients, or whose patients die without being admitted to the hospital. We are already seeing the impact of these perverse incentives in hospital-level programs that target readmissions. At the hospital level, "success" on the 30-day readmission metric (relative to "predicted", the latter based on a weak predictive model) has been found to be associated with an excess mortality over the same time frame. If CMS were to shift this framework to MIPS and penalize individual providers by essentially capping the number of patients "they" may hospitalize, this would create a powerful

disincentive to deliver potentially life-saving care and could be disastrous for our patients, particularly the sickest and most vulnerable ones.

HFSA strongly supports efforts to improve ambulatory care quality and care coordination, but we believe that clinician-level measurement of heart failure management needs to shift its focus from pure utilization metrics to coupling utilization with quality care delivery and reducing adverse events. For example, clinician-level metrics should focus on providing guideline-directed medical therapy (GDMT) and improving management of hypertension and diabetes, which all have the potential to reduce hospitalizations by making our patients healthy. Outcomes, namely survival, should be measured at the hospital-level. Similarly, it would be much more valuable to evaluate whether systems are in place to arrange follow-up care— for example, counting a hospital readmission if the patient did not have a follow-up arranged in 7-10 days or the hospital did not discharge a patient on GDMT. Clinician-level metrics should incentivize the adoption of these processes and tools that drive quality and favorable outcomes, including reductions to both hospitalization rates and mortality.

We also remind the NQF that every major heart failure trial looking at hospitalizations as an adverse event does so accounting for the competing risk of death (i.e., if the patient dies, he/she will not be hospitalized). This measure does not seem to account for the competing risk of death and it is unclear if CMS would simultaneously evaluate excess number of deaths per capita. Finally, we remind the NQF that heart failure patients have multiple comorbidities. In fact, more than half of hospitalizations among these patients are unrelated to worsening heart failure. As we previously expressed to the Measures Application Partnership (MAP), the risk adjustment methodology associated with this measure is inadequate in that it relies exclusively on claims data and on generally rigid variables that do not fully account for severity of illness, medical complexity, and social determinants of health, all of which are critical drivers of heart failure admissions. Similarly, this measure does not adjust for social determinants and other risk factors. Many patients make appointments and just do not show for follow-up. It is also not uncommon that they do not fill medications; often these patients are underprivileged or underinsured and cannot afford medications (especially in January of each year when copays start over). Thus, if a patient does not own a car and does not have a smart phone or internet access for e-visits, the clinician is limited in his/her ability to prevent readmissions.

Developer Response:

Yale/CORE has replied below to each subtopic within the HSFA's comment, repeating their comment for context.

HFSA Comment: On behalf of the Heart Failure Society of America (HFSA), we are writing to provide comments on the Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under MIPS measure (#3612) currently under consideration by the NQF's All-Cause Admissions and Readmissions Committee. HFSA is a multidisciplinary organization working to improve and expand heart failure care through collaboration, education, research, innovation, and advocacy. Its vision is to significantly reduce the burden of heart failure.

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appropriate strategy for measurement of this patient population, particularly in a pay-for-performance program, would be to focus on actions that are in the direct control of the physician or else to use this type of measure for facility or system-level accountability (e.g., ACOs, the VA, etc.).

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Yale/CORE Response: Yale-CORE appreciates the concerns raised by the HFSA. The measure is focused on acute unplanned CV-related admissions because they represent an actionable subset of admissions that can be influenced by primary care providers (PCPs) and cardiologists. Acute CV-related admissions occur when outpatient management of HF fails, or when patients develop new or worsening symptoms or CV complications. There is strong evidence supporting the assertion that ambulatory care clinicians can influence acute unplanned cardiovascular-related admission rates by providing high quality of care [1-7]. For example, Brown et al. pointed to four ambulatory care-focused Medicare Coordinated Care Demonstration programs that reduced hospitalizations for high-risk patients by 13-30 events per 100 beneficiaries per year (8-33% of hospitalizations). Brown et al. highlighted six program features that were associated with successfully reducing hospitalizations: 1) supplementing patient telephone calls with in-person meetings; 2) occasionally meeting in-person with providers; 3) acting as a communication hub for providers; 4) providing patients with evidence-based education; 5) providing strong medication management; and 6) providing comprehensive and timely transitional care after hospitalizations [1]. In addition, van Loenen et al. found that higher levels of provider continuity decreased the risk of avoidable hospitalizations for ambulatory care-sensitive conditions (ACSCs) and chronic diseases [6]. Hussey et al. [8] found that among Medicare beneficiaries, greater continuity of care was associated with lower hospitalization odds (OR=0.94, CI=0.93-0.95). Favorable results (declines in admissions) were also shown by Dorr et al. (2000), Levine et al. (2012), Littleford et al. (2010), and Zhang et al. (2008) [2-4, 7]. Several studies have demonstrated positive impact of early follow-up after hospitalization to reduce readmissions for HF [9-12].

The measure aims to incentivize effective and coordinated care for patients with HF to reduce the rates

of these admissions. In designing this measure, CMS took into consideration the types of acute hospital admissions that ambulatory providers caring for patients with heart failure could be held accountable for and excluded those that do not reflect the quality of ambulatory care. Because ambulatory providers may not be able to control all of the factors that drive CV-related acute hospital admissions among patients with heart failure, the measure is carefully risk adjusted for comorbid conditions, severity of heart failure, frailty and disability, as well as for the AHRQ SES Index, a marker of socioeconomic disadvantage. We note that the target rate of admissions is not "capped" nor is it zero since disease progression often necessitates hospital admission to stabilize and treat CV complications; rather, the measure assesses whether the admission rate for providers' patients is higher than expected given their risk factors.

We agree that some process measures, e.g., those focused on adoption of guideline-directed medical therapy in patients with heart failure or those focused on achievement of blood pressure or glycemic control targets, can be used to incentivize quality improvement for patients with heart failure. However, they do not capture all of the actions that clinicians can take to influence favorable outcomes. Moreover, patients are interested in surviving, avoiding hospital admissions, minimizing symptoms, achieving optimal functioning, and optimizing their quality of life. No set of process measures can be comprehensive enough to serve as a surrogate for these patient outcomes. Thus, CMS prioritizes the use of outcome measures to evaluate quality in MIPS.

CMS will continue to monitor for any unintended consequences of the measure. CMS notes that although thresholds to admit a patient with HF from the emergency department (ED) to the hospital can be variable, they are unlikely to be unduly influenced by ambulatory MIPS clinicians. When patients present with an acute illness to the ED, the decision to admit or discharge a patient is generally made by the ED physician. Therefore, it is unlikely that the measure would incentivize changes in thresholds to admit a HF patient or create caps on the number of patients admitted. In addition, the measure uses claims codes that are subject to auditing in order to minimize fraudulent coding.

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HSFA Comment: We also remind the NQF that every major heart failure trial looking at hospitalizations as an adverse event does so accounting for the competing risk of death (i.e., if the patient dies, he/she will not be hospitalized). This measure does not seem to account for the competing risk of death and it is unclear if CMS would simultaneously evaluate excess number of deaths per capita.

Yale/CORE Response: Yale-CORE appreciates the concerns about mortality as a competing outcome; this concern was taken into account during development of the measure since patients with HF are at high risk of both hospital admissions and mortality. The measure does not favor providers with higher mortality rates for two reasons. First, patients who die in the measurement year tend to be admitted more often in that year. Second, when a patient dies, he/she no longer contributes time to the measure denominator (person-years). A better score on the measure is achieved by helping patients stay alive and contribute to the denominator while avoiding hospitalization.

HSFA Comment: Finally, we remind the NQF that heart failure patients have multiple comorbidities. In fact, more than half of hospitalizations among these patients are unrelated to worsening heart failure. As we previously expressed to the Measures Application Partnership (MAP), the risk adjustment methodology associated with this measure is inadequate in that it relies exclusively on claims data and on generally rigid variables that do not fully account for severity of illness, medical complexity, and social determinants of health, all of which are critical drivers of heart failure admissions. Similarly, this measure does not adequately adjust for social determinants and other risk factors. Many patients make appointments and just do not show for follow-up. It is also not uncommon that they do not fill medications— often these patients are underprivileged or underinsured and cannot afford medications (especially in January of each year when copays start over). Thus, if a patient does not own a car and does not have a smart phone or internet access for e-visits, the clinician is limited in his/her ability to prevent readmissions.

Yale/CORE Response: Yale-CORE appreciates this input. The measure accounts for patients with more complicated or severe heart failure in several ways: 1) by excluding patients at advanced stages of heart

failure, such as those with implanted left ventricular assist device (LVAD), those who receive home inotropic therapy, or those with prior heart transplant or with end stage renal disease; 2) by risk adjustment for AICDs (defibrillators); 3) by risk adjustment for systolic heart failure; 4) by risk adjustment for comorbidities including chronic kidney disease, and for frailty/disability; and 5) by not including advanced heart failure/transplant specialists for attribution. Four residential and community context variables were evaluated for possible inclusion in the risk-adjustment model: 1) the AHRQ SES Index, 2) rural residence, 3) PCP density, and 4) cardiologist density, and one individual level variable: Medicare-Medicaid dual eligibility. Given the measure conceptual model, empiric findings, and feedback received from the national TEP and Clinician Committee during measure development, CMS decided to adjust the measure for the AHRQ SES Index. The AHRQ SES Index variable captures multiple aspects of social deprivation that can impact patients' health and health outcomes, including poverty and median household income; unemployment; education; and housing value and quality. These factors are deeply rooted in societal disparities, and MIPS providers may have little ability to influence their effect. However, ambulatory providers can work with patients to improve on their continuity of care, adherence to prescribed medications, and access to appointments.

NQF Response: Not applicable.

NQF Committee Response:

Thank you for your comment. The Standing Committee and NQF Scientific Methods Panel (SMP) considered the attribution and the risk adjustment model for the measure. Both the SMP and Standing Committee reviewed this information during the measure evaluation proceedings. The SMP passed the measure on both reliability and validity, in which attribution and risk adjustment are considered. The Standing Committee upheld the SMP's rating for reliability and validity and voted to recommend this measure for endorsement. NQF criteria considers unintended consequences in the usability criterion. However, for new measures that are not in use, data on unintended consequences is often not available due to the measure not being used. Therefore, the Standing Committee acknowledges the need to assess the potential for unintended consequences and considered this in its vote to recommend the measure for endorsement. The Standing Committee further recommends that the developer and CMS continue to monitor the measure for unintended consequences as results of its use.