Kansas Hospital Association

February 6, 2024

Partnership for Quality Measurement
Pre-Rulemaking Measure Review (PRMR) Final MUC Recommendations
Public Comment

To Whom it May Concern:

On behalf of our 122 acute-care community hospital members across Kansas, the Kansas Hospital Association (KHA) appreciates the opportunity to provide comments on the final Measures Under Consideration (MUC) recommendations for the 2023 Pre-Rulemaking Measure Review (PRMR). Our comments below follow the initial comments KHA submitted on-line December 21, 2023.

Of KHA's 122 hospital members, 82 are critical access hospitals (CAHs). There are 105 counties in Kansas, of which 36 counties are Frontier, 32 counties are Rural, 21 counties are Densely-settled Rural, and the remainder are Semi-urban or Urban. While frontier is often defined as counties having a population density of six or fewer people per square mile, this simple definition does not take into account other important factors that may isolate a community and make the availability of services, workforce recruitment and sustainment, and financial sustainability challenging. Many of the proposed measures do not appear to contemplate the delivery of health care in a rural or frontier area, such as the social determinants of health measures.

KHA urges the Centers for Medicare and Medicaid Services (CMS) to take into consideration challenges that hospitals continue to face related to workforce shortages and financial sustainability throughout the measure review process. KHA is very concerned about the volume of measures intended for hospitals programs included in the MUC list. Of the 25 measures assigned to the hospital workgroup, more than half (13) would be new to CMS programs. KHA urges CMS to continue to utilize a meaningful measures approach to quality measurement and consider what measures should be removed while new measures are added. As hospitals continue to be challenged with workforce shortages, reducing burden and focusing on measures that add value is even more critical. To the extent CMS intends to adopt any of the measures on this year's MUC list in future rulemaking, KHA strongly urges the agency to also remove measures that no longer add value.

Please find below KHA's comments on the 2023 PRMR final MUC recommendations.

MUC2023-049 - Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)

As shared in our December 21, 2023 comments, the Kansas Hospital Association is concerned that the Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure to Rescue) disregards site of death. KHA believes that disregard for site of death in this measure introduces many scenarios outside of a hospital's control. It appears that this measure is an updated version of Patient Safety Indicator 4 (PSI 4), a longstanding IQR measure with low reliability. Assuming this measure continues to be based solely on billing data, it will continue to be of low reliability and subject to disconnects between performance captured in billing data and clinical reality that have long limited the utility of the PSI measures used in CMS programs. We appreciate that the committee acknowledges potential unintended consequences of this measure, but we disagree with the committee's decision to recommend with conditions. KHA urges CMS not to adopt this measure until further study is conducted regarding the impact of disregarding site of death and potential changes needed to the exclusion criteria to make this a meaningful metric.

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MUC2023-117, -119, -120 - The 3 Excess Days in Acute Care (EDAC) measures – 117 (AMI), 119 (HF) and 120 (PN)

The Kansas Hospital Association questions the validity of the excess days in acute care (EDAC) measures as noted in our December 21, 2023, comments. The EDAC measures: 117 - After Hospitalization for Acute MI (AMI); 119 - After Hospitalization for Heart Failure (HF); and 120 - After Hospitalization for Pneumonia (PN) with the readmissions being for all causes. If the measure is specific to a diagnosis, we believe that the readmission measure should be specific to the diagnosis as well. It seems inappropriate to add these measures for specific conditions, but then open up to all causes. This measure is especially concerning with regard to complex patients with multiple co-morbidities. Additionally, KHA questions whether the statute authorizing the Hospital Readmissions Reduction Program (HRRP) permits CMS to use the EDAC measures in the program. This concern stems from the statutory definition of readmissions at 42 USC 1395ww (q)(5)(E): "The term "readmission" means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge." The HRRP statute does not contain the terms "emergency department" or "observation stay". Furthermore, the definitions of "admissions" to inpatient beds, emergency department visits and observation stays are not used interchangeably in other CMS regulations. For example, emergency department visits in which a patient returns home to the community are not "admissions". KHA notes that the PRMR committee did not reach consensus on 117, and recommended 119 and 120 with conditions. We urge CMS not to adopt the EDAC measures for the HRRP.

MUC2023-146 – 149 – Hospital Patient Experience of Care

KHA appreciates that CMS is working to modernize the HCAHPS survey. However, our organization questions the validity and reliability of the newly proposed hospital patient experience of care questions. Specifically with regard to 147, Restfulness of Hospital Environment, patients who require care in an inpatient setting will be treated and monitored, which by necessity will likely cause disruption in a patient's rest based on the patient's acuity, frequency of required monitoring, medication, therapies and other services. Further, KHA questions if all sub-measures would replace existing questions or be added to an already lengthy survey. Other questions include how data gleaned from these sub-measures could be used to improve performance, as the preliminary analysis noted that the measures are not based upon clinical practice guidelines. KHA requests that all of the newly proposed hospital patient experience of care measures undergo further validity and reliability testing before they are proposed for a CMS program.

MUC2023-156, 171, and 176 - Social Determinants of Health and Hospital Commitment to Health Equity

These three measures appear to be identical to the measures adopted in the Inpatient Quality Reporting program. Extending these measures to the Outpatient Quality Reporting (OQR) Program raises concerns in regard to resources needed for assessments and resolution of screened patients when hospitals continue to be challenged with significant workforce shortages. Additionally, KHA asks that CMS provide feedback on how the agency intends to use these health equity-related measures in the OQR. Does the agency intend to utilize the measures as it has with other measures used in both programs, such as the COVID-19 Vaccination Among Healthcare Personnel measure, where a single rate is reported at the facility level that includes both inpatient and outpatient services? KHA urges CMS to consider that many frontier and rural communities lack the resources needed to address health related social needs. Flexibility to screen for and refer to services that are available in rural communities is needed, as screening for issues for which there are no resources to address could undermine the health care provider - patient relationship.

MUC2023-199 – Connection to Community Service Provider and MUC2023-210 - Resolution of At Least 1 Health-Related Social Need

KHA is concerned that 199 - Connection to Community Service Provider - does not take into account many critical issues associated with connecting patients to services in rural and frontier communities. Many rural, especially frontier communities, do not have community service providers that can address or have the resources available to address

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health related social needs. We ask that there be an exclusion for patients residing in communities where there are no community service providers to address the patients' health related social needs, such as transportation, housing, food instability. Further, a significant safety concern is for patients who identify interpersonal safety as an issue. Documentation of any health related social need for patients who are victims of domestic violence could put those patients at increased risk. We believe that thoughtful consideration must be given to protecting patients who are victims of domestic violence and consider the unintended consequences of required reporting on this measure, and who would have access to the information provided to connect these patients to services.

Additionally, KHA is concerned that 210 - Resolution of at Least 1 Health-Related Social Need - will penalize hospitals in communities that do not have community service providers (CSPs) or other resources to address one or more health-related social needs. Rural and frontier communities lack CSPs with resources to address health-related social needs. Very few CSPs exist in rural Kansas communities that are able to address transportation, housing needs or food instability. Further, our organization has the same concern as expressed regarding measure 199 - Connection to a Community Service Provider - and protecting the identity of patients who are victims of domestic violence. Our organization requests that this measure be tabled until a reimbursement structure is developed to reimburse hospitals for connecting patients to CSPs who are able to resolve their health-related social needs. Further, we ask that patients who reside in communities that do not have a CSP to address their health-related social need be excluded. KHA is concerned that performance on this measure will be more reflective of factors outside of a hospital's control, such as the economic health of the patient's community or availability of community providers, than of provider performance.

MUC2023-212 - Medicare Advantage Star Ratings Denials Measure

KHA supports MUC-212, Level 1 Denials Upheld Rate. KHA urges CMS to provide greater transparency around the extent to which Medicare Advantage Organizations (MAOs) engage in inappropriate coverage denials as well as accountability for those MAOs with high rates of denials. MUC-212 provides insight into whether MAOs are making appropriate initial coverage denial decisions by measuring the extent to which health plans themselves uphold their own Level 1 coverage denials. Lower performance on the measure would indicate that an MAO is being too aggressive in its initial coverage denial decisions and possibly applying more restrictive criteria than Traditional Medicare, thereby contributing to delays in beneficiaries receiving necessary care. This is especially important in the context of recent findings from the U.S. Department of Health and Human Services Office of Inspector General, which found that MAOs overturned 75 percent of their own initial denials upon appeal during a 2 year period, raising concerns that MA enrollees and their providers are routinely being denied services and payments that should have been provided. Inappropriate coverage denial decisions contribute significant administrative and cost burden to patients and health care providers. The inclusion of MUC-212 in the MA Star Ratings system would provide public visibility and financial consequences for denial rates, thereby discouraging MAOs from denying care inappropriately.

KHA appreciates the opportunity to comment on behalf of Kansas hospitals and your consideration of our comments. For questions, feel free to contact me at kbraman@kha-net.org.

Sincerely,

Karen Braman
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