Consumer-Purchaser
ALLIANCE
Better information. Better decisions. Better health care.

June 16, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS-1632-P: Proposed Changes to FY 2016 Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; and Quality Reporting Requirements for Specific Providers.

Dear Mr. Slavitt:

The 17 undersigned organizations represent a collaboration of leading consumer, labor, and employer organizations, committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment and quality improvement. We appreciate the opportunity to submit comments to CMS on the proposed changes to the FY 2016 Medicare Inpatient Prospective Payment System (IPPS) rule. The detailed comments that follow this letter pertain to the following sections of the Notice of Proposed Rule Making (NPRM):

- Non-Payment for Preventable Hospital-Acquired Conditions (HACs)
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital-Acquired Conditions Reduction Program
- Hospital Inpatient Quality Reporting Program
- Electronic Health Record Incentive Program

We commend CMS's leadership in its ongoing implementation and refinement of federal inpatient hospital programs that seek to achieve the goals of the National Quality Strategy through increased transparency and the promotion of payment that rewards quality over volume. In particular, we are pleased to see this proposal's emphasis on:

- Adding new measures that are meaningful to consumers and purchasers (outcomes, patient-reported outcomes, and efficiency)
- Refining important outcome measures to include more patients[1]

[1] For brevity, we refer in various places in our comments to "patient" and "care," given that many federal programs and initiatives are rooted in the medical model. To some, these terms could imply a focus on episodes of illness and exclusive

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- Removing low value measures (e.g., topped out, process measures)
- Strengthening electronic measurement infrastructure for more feasible collection of high value measures

In spite of this momentum, we remain concerned that programs are not evolving at a pace that matches expectations of consumers and purchasers. In particular, we were disappointed with the lack of new measures for the Readmissions Reduction, VBP, and HAC Reduction Programs.

- We urge CMS to devote resources to measure development that can fill critical gaps, particularly in areas of care where patient-reported data provide insight on experience of care, outcomes and functional status.
- All patients should receive appropriate care. Yet few existing measures capture overuse of tests and treatments or the use of expensive drugs and devices when less expensive but equally effective alternatives exist.
- We support CMS moving forward with development of all-cause harm measures, as discussed during the MAP proceedings for 2015. Measures of harm, i.e., outcomes that negatively impact health and quality of life, are extremely important to both consumers and purchasers.
- We remain concerned with the number of and continued reduction in weighting of patient safety measures in the HAC Reduction Program.

We encourage CMS to prioritize retooling measures to fill these gaps or developing new measures in these areas.

Identification and amelioration of disparities in access to care, experience of care, and health outcomes remain a priority for consumers and purchasers. One approach to identifying these disparities – risk adjustment of performance measures for sociodemographic factors – is now being tested through the National Quality Forum. However, this multifaceted problem requires multiple approaches, and we encourage CMS to pursue additional ways to identify health disparities and ensure that providers have sufficient resources to care for underserved communities such as the stratification of performance measures by sociodemographic factors. In addition, we encourage CMS to explore ways to identify health disparities more efficiently and effectively through infrastructure improvements like the collection of sociodemographic factor variables via electronic health records.

We emphatically recommend CMS publicly report data in a way that puts the needs of consumers first and foremost. Fundamental to meeting that goal is to collect and report data for individual facilities (i.e. campuses and locations), not by Medicare Provider Number (MPN) or CMS Certification Number (CCN). We know there is variation in the quality of care provided by hospitals that are affiliated with each other. When results are reported in aggregate, individual performance is obscured. This is misleading to patients.

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dependency on professionals. Any effort to improve patient and family engagement must include the use of terminology that also resonates with the numerous consumer perspectives not adequately reflected by medical model terminology. For example, people with disabilities frequently refer to themselves as "consumers" or merely "persons" (rather than patients). Similarly, the health care community uses the terminology “caregivers” and “care plans,” while the independent living movement may refer to “peer support” and “integrated person-centered planning.”

In the appendix we further elaborate on these concerns and provide more detailed comments and recommendations on the individual programs noted above.

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the proposed changes to the IPPS rule. If you have any questions, please contact either of the Consumer-Purchaser Alliance's co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely,

Organizations listed in alphabetical order
AARP
The Alliance
Commonwealth of Massachusetts Group Insurance Commission
The Empowered Patient Coalition
Health Care Incentives Improvement Institute
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
The Leapfrog Group
Maine Health Management Coalition
Memphis Business Group on Health
Mothers Against Medical Error
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Pacific Business Group on Health
PULSE of America
St. Louis Area Business Health Coalition
Wyoming Business Coalition on Health

Appendix

Non-Payment for Preventable Hospital-Acquired Conditions (HACs)

Measures of preventable hospital-acquired conditions provide important information on the quality of care provided by hospitals. As previously requested by consumers and purchasers, we urge CMS to publically report on an annual basis the results from measures included in this program. The removal of these measures is a setback to the hard work that has been done by CMS, consumers, purchasers and other stakeholders to promote better transparency over the last several years. For instance, the removal of publically reported information on hospital-acquired conditions included in Leapfrog's Hospital Safety Score will put consumers at risk of losing yet another resource that offers them meaningful information to help guide their care decisions.

CMS indicated it will continue to evaluate whether or not additional hospital-acquired conditions should be added to this program. We believe other measures should be added to this program. We recommend CMS add measures of surgical site infections following high-volume procedures, such as cesarean section surgery, hip replacement and knee replacement surgery.

Hospital Readmissions Reduction Program (HRRP)

C-P Alliance continues to support this program and believes it serves as an important policy lever that drives improvement in patient care. Moreover, we believe this program supports innovation that addresses patient outcomes, far beyond readmissions, by encouraging increased shared accountability, communication, and coordination across providers and the full continuum of patient care. We are pleased by the progress already achieved, but there remains opportunity for improvement as rates across conditions have not uniformly improved. Given this, we are very disappointed new measures have not been added for the past two years, and are concerned about losing momentum. We encourage CMS to continue to strengthen this program through the inclusion of new measures by introducing additional condition-specific readmission measures.

Revision of Measure for FY 2017

C-P Alliance believes that the more patients captured in this program, the greater its capacity to reduce avoidable readmissions for *all* patients. We therefore support the implementation of the expanded patient population for CMS 30-Day Pneumonia Readmission Measure (NQF #0506) to include patients with aspiration pneumonia and patients with a principal discharge diagnosis of either sepsis or respiratory failure who also have a secondary diagnosis of pneumonia present on admission. Including such patients will better represent the complete population of a hospital's patients who are receiving clinical management and treatment for pneumonia, as well as to ensure the measure includes more complete and comparable populations across hospitals. Additionally, expanding the measure cohort will increase the number of hospitals that meet the minimum threshold for inclusions.

Hospital Value-Based Purchasing Program (HVBP)

The HVBP Program provides financial incentives for hospitals to demonstrate performance improvement and attainment of the delivery of high quality care that is not based on the volume of services provided.

We urge CMS to continue to add measures to this program in a timely manner that reflect clear gaps in hospital performance.

New Measures for FY 2018 and beyond

We strongly support the recommendation to include the 3-Item Care Transition Measure (CTM-3). CTM-3 helps address the gap in care coordination measures through the use of person-reported data. The CTM-3 includes the three major areas that patients have identified in qualitative studies as critically important to their experience with coordination out of the hospital; namely understanding one's self-care role after discharge, medication management, and having one's preferences incorporated into the post-discharge care plan. We urge CMS to implement this measure sooner than FY 2018. This measure is NQF endorsed and meets the requirement for inclusion sooner as it has been in IQR since FY 2013 and posted on hospital compare December 2014. Moving forward, we also encourage CMS to develop a measure that captures information about patient transitions to outpatient care and community-based services. As hospitals are taking on a greater role in post-acute care coordination, understanding how well efforts to connect patients with external providers and social support systems will help to fill a critical gap.

We also support the inclusion of the 30-day, all-cause risk standardized mortality ratio following chronic obstructive pulmonary disease (COPD) (NQF #1893). COPD is a high cost, high volume condition with significant variation in mortality (median range of 5.5% to 12.4% for July 2010 to June 2013). We do not understand the delay in implementation as it currently meets the statutory requirements for inclusion. We urge CMS to implement this measure sooner than FY 2021 to FY 2018. Moreover, we recommend CMS consider developing measures of appropriateness for COPD to complement mortality to understand utilization of services, particularly for high acuity patients.

Finally, we support the expansion of the CAUTI and CLABSI measures to include select non-ICU locations. The expansion of the CAUTI and CLABSI measures is consistent with the NQF endorsement maintenance update, would apply to more patients, and include hospitals that do not have ICUs.

In addition to what CMS has already proposed, we support the recommendations by the MAP for inclusion of the following key outcome measures, all of which are already confirmed for inclusion in the IQR Program:

- PSI–4: Death among surgical inpatients with serious treatable complications (NQF #0351)
- AMI Payment Per Episode

Measures Proposed for Removal

We support the proposed removal of the two measures beginning with the FY 2018 program year:

- IMM-2 Influenza Immunization, which is a topped-out measure and
- AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival, which is not widely reported by hospitals because most AMI patients receive percutaneous coronary intervention instead.

Other Proposed Changes to the HVBP

We offer our support for the proposed updates to the scoring methodology for the safety and clinical care domains in this program, which will include the following domain weights:

- 25% Safety (previously 20 %)

- 25% Clinical Care (previously 30%: 25 % outcomes and 5% process)
- 25% Efficiency (no change proposed)
- 25% Patient- and Caregiver-Centered (PCC) Experience of Care/Care Coordination (no change proposed)

With CMS' focus on clinical outcomes, it becomes less necessary to differentiate weights for outcomes and process.

Hospital-Acquired Condition Reduction Program

We support CMS' implementation of the Hospital-Acquired Conditions (HACs) Reduction Program to increase transparency and accountability for key patient safety issues, and we applaud the program's success to date. We support the expansion of the CAUTI and CLABSI measures to include select non-ICU locations for the reasons above, and to be consistent in measure specifications across programs.

New Measures for FY 2016 and beyond

We are concerned that CMS has not proposed any additional measures for inclusion in this program in the near-term. Although 15,000 lives have been saved due to the prevention of HACs in recent years, there is still substantial room for improvement.

HACs are a source of significant patient burden and cost, yet many hospitals do not follow evidence-based guidelines that would contribute to their prevention. Measuring and reporting outcomes, e.g., the occurrence of avoidable HACs, will cause hospitals to examine and improve their processes. We recommend the inclusion of the MAP recommended measure PSI-16: Transfusion Reaction (NQF # 0349) for FY 2016. This NQF-endorsed outcome measure assesses illness or injury resulting from administration of mismatched blood or blood products. These events are considered to be almost entirely preventable. Additionally, we encourage CMS to address persisting gaps in this program relevant to adverse drug events, ventilator-associated events (VAEs), diagnostic errors, and a broader scope of surgical site infection measures. With regard to measures of medication safety in particular, we point to an existing measure from Brigham and Women's Hospital, Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (NQF # 2456).This outcome measure assesses errors in admission and discharge medication orders due to problems with the medication reconciliation process.

Other Proposed Changes to the HAC Reduction Program

CMS has proposed to adjust the weighting of the existing domains used to calculate hospitals' total HAC score in the following way:

- Domain 1, which consists of PSI-90: Composite Measure of Patient Safety for Select Indicators (NQF #0531), will be weighted as 15% (previously 25%) of the total HAC score
- Domain 2, which includes the Catheter-associated Urinary Tract Infection (NQF # 0138), Central Line-associated Blood Stream Infection (NQF #0139), Surgical Site Infection Measure (NQF #0753), MRSA (NQF #1716), and Clostridium difficile infection (NQF # 1717) measures, will be weighted as 85% (previously 75%) of the total HAC score.

This is the second year in a row CMS will reduce the patient safety and increase the infections domain weights. We do not support CMS' proposal to change the weighting again, as we feel that this approach promotes an overly narrow definition of HACs that places too much emphasis on infections alone.

While infections are certainly very important patient outcomes, patients are also exposed to risks from many of the outcomes in PSI-90, such as pressure ulcers, postoperative hemorrhage, sepsis or accidental puncture/laceration. CMS should take a more balanced approach to weighting the existing domains.

We also urge CMS to move to a more patient-centered way of measuring and reporting hospital-acquired infection rates. That is, the current infection control perspective of infections per thousand patient days should be replaced by the patient perspective of infections per thousand patient discharges. The current method masks the effect of length of stay and, hence, does not tell prospective patients their likelihood of acquiring an infection at a given hospital.

Hospital Inpatient Quality Reporting Program (IQR)

We appreciate the direction CMS has taken with this program, transforming it from a set of discrete process measures oriented toward internal quality improvement, into a comprehensive program that supports the transparency of meaningful measures that strive to meet the needs of multiple stakeholders. We are pleased with the inclusion of outcome measures addressing a broad scope of high-impact conditions and the degree of alignment with existing programs (e.g., EHR Incentive Program, Hospital Readmissions Reduction Program).

New Measures for FY 2018

We commend CMS for the proposed inclusion of 7 measures in the IQR Program for FY 2018 that address clinical episode-of-care payments and excess days in acute care. We support, with some reservations, the survey on patient safety culture.

Clinical Episode-of-Care Payment Measures

We are pleased to see the addition of these payment measures, which can be reported with measures of quality to help illustrate the value of health care to consumers and purchasers. These measures address a significant share of Medicare payments and potential savings for hospitalized and post-acute care patients and reflect high variation in payments. Additionally, clinical experts agreed for these measures that standardized payment is linked to care during the hospitalization. We recommend that CMS monitor the results of these measures with respect to volume of procedures in an effort to identity potential issues related to appropriateness of services.

Excess Days in Acute Care Measures

We strongly support the excess days in acute care measures. For some conditions, like AMI and HF, the increase in ED visits and observations stays raises the concern that readmission measures are not fully capturing the range of unplanned care post-discharge. An all-cause acute care utilization measure is beneficial to patients as any cause for acute care is undesirable and exposure to medical care has risks. It also addresses the unintended consequence of shifting patients outside of inpatient care.

Hospital Survey on Patient Safety Culture

We support, with reservations, the inclusion of the Hospital Survey on Patient Safety Culture. Generally we do not support structural measures and want measures that include results. However, there is research showing that patient safety surveys are effective in identifying problems and possible solutions. We would support this measure without reservations if CMS required the same survey for all hospitals instead of allowing hospitals to choose from six. Otherwise, we won't be able to compare results across

hospitals and it runs the risk of being a "check-the-box" measure. We urge CMS to evolve the measure to capture the results of the survey, not just that the survey was administered.

We support expanding the patient population for the CMS 30-day Pneumonia Mortality Measure (NQF #0468) and CMS 30-Day Pneumonia Readmission Measure (NQF #0506). As mentioned previously, including such patients will better represent the complete population of a hospital's patients who are receiving clinical management and treatment for pneumonia, as well as to ensure the measure includes more complete and comparable populations across hospitals.

For FY 2018, CMS proposes to require hospitals to report 16 of the 28 electronic clinical quality measures under the Hospital IQR Program that align with the Medicare EHR Incentive Program and span 3 different NQS domains. We strongly support this proposal. While we acknowledge that accurate data collection is an issue, we know that public reporting is an incentive to quickly address those issues. CMS is giving substantial notice of public reporting so these issues can be addressed prior to publication.

Measures Proposed for Removal

We strongly support the proposal to remove the 9 measures that are topped-out and/or had a change in guidelines. Topped-out measures offer no useful information about the quality of care provided or its outcomes, and create unnecessary administrative effort for providers. We do not, however, support maintaining these measures for voluntary electronic reporting in the IQR Program. The proposed inclusion of measures that have no demonstrated impact on quality improvement sends the wrong message about the goals of both programs and inappropriately distracts resources from areas that would more readily benefit from targeted attention.

Future IQR Measures and Topics

Safety/Care Coordination Measures

In addition to the proposed measures for inclusion in the IQR Program, we encourage CMS to prioritize measures that fill important gaps in patient safety, including:

- Three NQF-endorsed measures that look at the proportion of patients hospitalized with 1) AMI; 2) stroke; or 3) pneumonia, and who experienced a potentially avoidable complication either during the hospital stay, or in the 30-day Post-Discharge Period (NQF#0704, 0705 and 0708)
- Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (NQF #2456), which assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process.
- Outcome measures of patient falls, such as those currently under consideration for endorsement maintenance by the NQF patient safety committee: Falls with Injury (NQF #202), and Patient Fall Rate (NQF #141).

Maternity Measures

Hospitals with over 1,100 births per year are now mandated by The Joint Commission to collect and report the Cesarean measure. We are disappointed to see that the PC-02: Cesarean Section measure was not included on the list of measures proposed for the IQR. We strongly recommend the inclusion of this measure for FY 2016. CMS should also focus on the development of a multi-dimensional patient-reported composite measure of maternity care in the near-term, which could be collected six weeks

after birth to measure outcomes and identify common new-onset morbidities during a post-partum visit. Additionally, we recommend the adaptation of the generic Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure the experience of care of childbearing women and newborns. We also support the development of measures that evaluate unexpected maternal complications, such as post-cesarean section infection, complications among low-risk women, and vaginal birth after cesarean in low-risk women, which could build off of AHRQ's IQI #22. Lastly, we believe that the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)'s provider-level measures include several excellent candidates for CMS' future consideration of additional maternity measures (e.g., 03 Skin-to-Skin is Initiated Immediately Following Birth and 04 Duration of Uninterrupted Skin-to-Skin Contact).

Patient-Reported Outcome Measures

We urge CMS to identify additional measures that use patient-reported data to assess experience of care, outcomes, including functional status, particularly for high-impact and cross-cutting areas of care. Patient-reported outcome measures include information collected from patients to elucidate on aspects of their care in which they are the expert (e.g., pain management, activities of daily living, functional status). This information supports a collaborative care management model and shared decision-making when results are shared with both patient and provider.

Electronic Health Record Incentive Program

We are encouraged by CMS' move towards public reporting and accountability for provider performance based on electronic quality measures in both the IQR and EHR Incentive programs. We support alignment between these two programs, but urge CMS to implement a more person-focused approach that prioritizes measures of patient outcomes that reveal significant variation in performance.

In addition, we encourage CMS to align efforts with other agencies and with all stakeholders, including the vendor community and leaders in EHR adoption and person-centered care to implement concrete mechanisms that support the reporting of electronic quality measures of outcomes and patient-reported health status. Specifically, requiring public reporting of robust electronic measures (e.g. e-measures), such as the 30-day risk standardized AMI mortality e-measure, and components of the National Institutes of Health's PROMIS tool, should receive high priority. PROMIS measures patient-reported functional status. Patients deserve to know whether treatments that are intended to improve their functional status actually make a positive difference. Measuring functional status is also important to assessing appropriateness of care and whether a treatment was effectively administered. PROMIS promotes parsimony because it is cross cutting. It provides a stable of "general" surveys that can be used to measure patient functioning in various clinical areas. We recognize PROMIS may not be ready for "prime time" use but emphatically encourage CMS to lay groundwork for its use.

Simultaneously, advancement of both quality measurement and electronic reporting should include mechanisms for real-time, and bi-directional feedback from the patient, allowing patients to access and view data from their providers' electronic health records via patient portals, as well as contribute patient-generated health data that informs clinical decisions and could serve as the foundation for future measure development.

Finally, we strongly support CMS moving in the direction of requiring hospitals to electronically submit core clinical data elements and values. This information can improve the feasible collection of measures by improving risk-adjustment models and capturing all-payer data. Alignment of these standards between IQR and the Electronic Health Record Incentive Program is critical.