Consumer-Purchaser
DISCLOSURE PROJECT
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June 25, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS-1599-P: Proposed Changes to FY 2014 Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; and Quality Reporting Requirements for Specific Providers.

Dear Ms. Tavenner:

The 25 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 2014 Medicare Inpatient Prospective Payment System (IPPS) rules. 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), Including Infections
- Hospital-Acquired Conditions Reduction Program
- Hospital Readmissions Reduction Program
- Hospital Inpatient Quality Reporting Program (IQR)
- Hospital Value-Based Purchasing Program (HVBP)
- PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- Long-Term Care Hospital Quality Reporting Program (LTCHQR)

We agree with the direction CMS has charted for improving care for all patients, assuring transparency, and reducing unnecessary costs. While we strongly support many elements of this proposed rule, there are areas – particularly related to healthcare-acquired conditions – where we believe that CMS could take a leadership role to meet these goals more quickly.

We continue to be frustrated by the measure gaps that preclude CMS from addressing gaps in care in areas of importance to patients and purchasers. We again urge CMS to devote resources to filling these critical gaps that prevent a comprehensive review of performance in federal programs. Thus, in addition to our comments on the measures and methodologies proposed in this rule, we also provide recommendations for measure development.

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Finally, we continue our push for greater alignment between the public (both federal- and state) and private sectors' value-based efforts, and hope that CMS will pursue opportunities to work with private purchasers and the states to support consistency and to help providers avoid unproductive, duplicative activities. Working together, all purchasers and payers can send a strong signal to the market about the importance of improving care in priority areas. This will enable providers to focus on improvement, (rather than on fulfilling multiple, disparate measurement requests), reduce the burden of data collection, and optimize the use of resources. We look forward to working with CMS and other partners on these and related efforts.

Overall, we applaud the various proposals put forward for the programs listed above. Further,

- **We support CMS' drive toward pay-for-reporting and pay-for-performance measures that address the priorities of the National Quality Strategy's (NQS) three-part aim.** In this proposed rule, CMS succeeded in identifying measures relevant to several of the NQS domains, such as patient safety, care coordination, and efficiency and cost reduction. We encourage CMS to leverage opportunities for further inclusion of measures addressing person- and caregiver-centered experience and outcomes, the most up-to-date clinical practices for prevention and treatment, and community/population health.

- **We encourage the addition of measures that will serve to push alignment with other public and private sector efforts.** We welcome the proposed addition to the IQR of five measures targeting hospital readmissions, mortality, and cost, as well as the addition of measures that address high-volume patient safety issues to the Hospital Value-Based Purchasing (HVBP) Program. These measures align with the efforts being made in other CMS programs, as well as in the private sector, to improve quality. Moving forward, we recommend consistent prioritization of the highest volume patient safety concerns. For instance, rather than just considering the inclusion of MRSA Bacteremia and Clostridium difficile (c-diff) infection rates for future inclusion in the HVBP Program, we recommend the agency move to confirm inclusion of these measures as quickly as possible, in order to align with existing federal reporting programs and patient safety initiatives (e.g., the Partnership for Patients and the *National Action Plan to Prevent Health Care-Associated Infections*).

- **We recommend that CMS more urgently consider the inclusion of outcome measures in the IQR Program that have significance for all consumers, not just Medicare beneficiaries.** We appreciate CMS' discussion of including, at a future date, e-specified measures that target populations outside of Medicare such as cesarean section rates and breast feeding. However, we would strongly prefer that the agency go beyond considering them, and instead add them without delay. This would benefit not only consumers, but also private sector purchasers and payers for whom maternity care is a high cost area. We urge CMS to consider the quick adoption of these measures in the IQR, particularly measures that will be implemented in other programs, such as Meaningful Use Stage 2.

- **We support CMS' efforts to implement the Hospital-Acquired Conditions (HACs) Reduction Program to increase awareness of and accountability for HACs.** However, we urge CMS to speed up the timeline for including important measures (noted above) like MRSA and c-diff

outcomes. We also suggest – in our detailed comments below – an alternative to the two approaches being considered for which measures should populate Domain 1 of this program.

- **CMS should prioritize making all data in the IPPS quality programs available on *Hospital Compare* in a way that is understandable and usable, and wherever possible, this data should be stratified by race, ethnicity, language, gender and disability. (RELGD).** While measures in the IQR program are being reported in a way that is useful to consumers and purchasers, we are still waiting for better data display of HVBP data, as well as data from the new programs to reduce readmissions and HACs. We appreciate the proposal in the NPRM that CMS is considering new, graphic displays of data on *Hospital Compare,* and we urge that consumers be involved in all stages of this transparent process. In addition, RELGD-stratified information is a critical tool for identifying, and ultimately addressing and reducing, disparities in care.

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 Disclosure Project'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,

AARP
American Benefits Council
American Hospice Foundation
Business Health Care Group
Childbirth Connection
Commonwealth of Massachusetts Group Insurance Commission
Connecticut Center for Patient Safety
Consumers Union
Employers' Coalition on Health
Health Policy Corporation of Iowa
Iowa Health Buyers Alliance
Lamaze International
Memphis Business Group on Health
Midwest Business Group on Health
Mothers Against Medical Error
National Business Coalition on Health
National Partnership for Women & Families
New Jersey Health Care Quality Initiative
Northeast Business Group on Health
Pacific Business Group on Health
PULSE of Colorado
St. Louis Area Business Health Coalition
The Alliance
The Empowered Patient Coalition
The Leapfrog Group

ADDENDUM: DETAILED COMMENTS ON IPPS NOTICE OF PROPOSED RULEMAKING, FY 2014

Preventable Hospital-Acquired Conditions (HACs), Including Infections

The HAC non-payment program, established through the Deficit Reduction Act of 2005, gives CMS the authority to deny payment to a hospital for a condition that was acquired during a hospitalization, (i.e., not "present on arrival" when a patient entered a hospital for any reason). The program currently includes the following 14 HACs:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
- Manifestations of Poor Glycemic Control
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
- Iatrogenic Pneumothorax with Venous Catheterization
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

These HACs meet the statutory criteria of being high cost, high volume, or both, and are assigned to a higher paying MS-Diagnosis Resource Group (DRG) when present as a secondary diagnosis. Given the removal of the original eight HAC rates from the IQR, we are pleased that these HACs at least will continue to be included in the non-payment program. However, we strongly believe that CMS should publicly report all data collected via pay-for-reporting, pay-for-performance, or any other payment program, particularly since two of the HACs listed above – air embolism; and falls and trauma— are not planned for inclusion in the HAC Reduction program. We appreciate CMS' commitment to being a strong partner in transparency efforts. However, we do ask that the agency identify where these rates will be publicly reported (whether on *Hospital Compare* or another HHS website), the timing of data updates, and whether these data will continue to be made publicly available after 2013.

Finally, we again recommend that CMS expand the non-payment program to include additional surgical site infections (SSIs) for three procedures: cesarean section surgery, total hip replacement, and total knee replacement. These procedures are both high volume and high cost. Including SSIs for cesarean section would provide an appropriate measure to pair with the C-section rate measure being considered for the IQR program. Similarly, CMS recognizes the risk to patients during hip and knee surgeries, as reflected by the DVT/PE HAC, and by the proposed inclusion of the measure of unplanned readmission for total hip and total knee surgeries in the hospital readmission reduction program. Overall, the addition of these SSIs to the non-payment program would not only benefit consumers, but also establish strong groups of measures for maternity/perinatal care, and for orthopedic care.

HAC Reduction Program

We appreciate the opportunity to comment on the inaugural round of rulemaking for this new program, and believe that it will have a significant effect on overall patient safety and outcomes. While CMS proposes a number of strong measures, we believe that if the goal is to incent hospitals to create a safe environment for all patients, the program must be expanded to include as many meaningful HAC measures as are currently available.

The proposed rule lays out two sets, or domains, of measures for consideration in developing the scoring methodology. Domain 1 includes AHRQ Patient Safety Indicator (PSI) measures and Domain 2 includes CDC measures that rely on data submitted through the National Healthcare Safety Network (NHSN). CMS asks for comments on whether Domain 1 should include ***either*** six unique PSIs, ***or*** the composite measure PSI-90: Patient Safety for Selected Indicators (See Table 1 below).

Table 1: Domain 1 of AHRQ Patient Safety Indicators

Approach A: Use Individual PSIs	Approach B: Use one HAC Composite Measure
PSI-3: Pressure Ulcer Rate PSI-5: Foreign Object Left in Body PSI-6: Iatrogenic Pneumothorax Rate PSI-10: Postoperative Physiologic and Metabolic Derangement Rate PSI-12: Postoperative PE/DVT Rate PSI-15: Accidental Puncture and Laceration Rate	*PSI-90 Includes the following measures rolled up into one composite:* PSI-3: Pressure Ulcer Rate PSI-6: Iatrogenic Pneumothorax Rate PSI-7: Central Line Blood Stream Infection Rate PSI-8: Postoperative Hip Fracture Rate PSI-12: Postoperative PE/DVT Rate PSI-13: Postoperative Sepsis Rate PSI-14: Wound Dehiscence Rate PSI-15: Accidental Puncture and Laceration Rate

Rather than Approach A or B, we propose *Approach C*: use Approach A, and add to it the following PSIs: 4, 8, 13 and 14. PSIs 8, 13, and 14 are listed above as part of the composite measure. PSI-4, *Death among Surgical Inpatients with Serious Treatable Conditions*, is absent from the proposed rule entirely, despite the fact that it has already been implemented in the Inpatient Quality Reporting Program (IQR) and had the support of the Measure Applications Partnership. We believe that *Approach C* will provide a more comprehensive and meaningful set of measures from which to develop the HAC score, and will drive greater improvements in patient safety.

Regarding Doman 2, we strongly support the inclusion of ICU Central Line-Associated Blood Stream Infections (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) rates. However, we question why these measures are only going to be applied to the ICU population when they have been re-specified by the measure developer to apply broadly across the inpatient setting. CLABSI and CAUTI measures are extremely important to identifying patient safety gaps, and they occur across all inpatient departments. We urge CMS to broaden the scope of the population for whom these measures will apply and reported in *Hospital Compare*. In addition, we urge CMS to include measures of MRSA and c-diff rates in this domain as well. These are arguably the most critical HACs affecting patients today, and they should be included in this reduction program particularly since they are NQF-endorsed measures, and have been finalized for inclusion in the IQR.

In addition to the two Domains outlined in the proposed rule, we urge CMS to consider a third Domain, made up of two additional important measures: 1) *Procedure-Specific Surgical Site Infections (*NQF #0753), and 2) a measure of medication errors. Surgical Site infections are a high volume HAC and should be included in this program. Medication errors comprise the highest volume of patient safety events in the hospital today, with evidence showing on average that one medication error occurs with at least one patient, every single day in each hospital. This creates an enormous burden on patients, and should not be left out of these calculations.

In terms of making the HAC Reduction program data transparent, we note that the Domain 2 measures have been specified to calculate a *Standardized Infection Ratio* (SIR) rather than an actual infection rate. The HAC Reduction Program's goal is to reduce the risk of preventable medical harm. The SIR does not measure the preventable harm at specific hospitals, but rather it simply shows a hospital's progress over time in reducing HACs from a prior point in time. However, since CMS has the data to calculate straightforward rates of these HACs we urge the agency to provide both the rate as well as the SIR in public reports. The SIR is certainly useful to hospitals for their quality improvement activities, given that it shows progress over time following a baseline period. However, consumers will find that information less useful than they would the rate of occurrence, which indicates a consumer's risk of contracting a HAC in a particular institution. Since CMS is able to satisfy the needs of both of these end users, we hope CMS will publish the SIR and the actual rate for these measures.

Finally, we request clarification on the time frames for updating these data on *Hospital Compare.* The proposed rule notes that CMS will use two-year periods for collecting the HAC data. If this leads to a two-year lag time in data updates, we fear that the goal of making HAC data usable by the consumer will not be achieved because the data will not be current. We strongly suggest that the HAC data be updated quarterly, with as short a lag time as possible so that consumers have timely information to base their decisions.

Hospital Readmissions Reduction Program

The Affordable Care Act established the Hospital Readmissions Reduction Program to address the high rates of preventable hospital readmissions. As of October 2012, hospitals have been assessed on their 30-day risk-adjusted readmission rates for patients with Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia (PN). As we know from media coverage of this program, the overall readmission rate over the past twelve months has fallen from 19 percent to 17.2 percent for unplanned hospital admissions. Further, MedPac's June 2013 Report to the Congress indicates that at a national level, all-cause readmissions for the three reported conditions had a larger decrease in readmissions over the three-year measurement period than for all conditions, suggesting a strong connection between public reporting and implementation of the Hospital Readmissions Reduction Program. The results tell a compelling story that underlies the adage that "what gets measured gets attention." It is clear that linking financial incentives to publicly reported, standardized quality metrics has driven, and will continue to drive, significant improvement in patient outcomes and reduce unnecessary costs to the system.

We support the use of the three revised NQF-endorsed risk-adjusted readmission rate measures for Acute Myocardial Infarction (AMI), Pneumonia (PN), and Heart Failure (HF), and are pleased to see that they have been re-specified to exclude specific planned readmissions. We are confident that these measures (which also adjust for patient demographic factors, coexisting medical conditions and

indicators of patient frailty, and exclude transfers to acute care facilities) provide accurate, appropriate data from which payment penalty decisions can be made.

We also support the proposed addition of readmission rate measures for COPD and total hip replacement and total knee replacement. These conditions/procedures affect a significant volume of patients, and also account for a high percentage of the costs associated with unplanned readmissions. Particularly for patients undergoing total hip and/or total knee replacement, the challenges associated with recovery are difficult enough without the potential for an unplanned hospital readmission; any effort to reduce these events will not only contribute to higher quality care for patients, but will also significantly reduce costs.

Beyond the specific conditions/procedures being proposed, we commend CMS for moving quickly beyond the three conditions mandated in the Affordable Care Act (AMI, PN and HF). The more conditions and procedures captured in this program, the greater the opportunity for hospitals to apply what they have learned from addressing the initial three conditions to other areas. Thus, we are concerned as to why CMS ignored MedPAC's recommendation to include readmission measures for Coronary Artery Bypass Graft (CABG) and Percutaneous Coronary Intervention (PCI) since we agree there is strong justification for their inclusion in the program.

According to data from the American College of Cardiology's CathPCI Registry, in 2012 almost 80 percent of PCI patients were overweight, including 43 percent who were obese. In addition, 80 percent had dyslipidemia, 82 percent had hypertension, and almost 28 percent of PCI patients were current or recent smokers. The potential for these PCI patients to experience an unplanned readmission due to complication factors related to their risk factors is very high. This is a prime population for whom care transitions and better strategies for connecting patients to needed community-based supports can make a significant impact in terms of avoiding unplanned readmissions. There is also burgeoning evidence that the volume of PCIs performed is indirectly proportional to the cost of follow-up care for patients, which may indicate that patients who receive their PCI at a low-volume facility may experience unplanned readmissions. Collecting data on this and directing facilities' attention to what can be done to address this challenge will be a benefit not only to consumers, patients and their families, but to the system as a whole.

As in last year's comments, we continue to be concerned with the effect of the Hospital Readmissions Reduction Program on safety net hospitals. The current data still indicate that safety net hospitals and other hospitals that serve disproportionately high percentages of low SES patients see a higher-than-average rate of unplanned readmissions. The data also show a strong correlation between the lack of family and community supports and the probability of an unplanned hospital readmission. Of course, we do not subscribe to the notion that hospital serving lower SES patients can be given a "pass" to provide sub-standard care. In fact, many hospitals serving lower-income populations are finding innovative ways to reduce readmissions. Examples include New York Methodist Hospital – a CMS Community-Based Care Transitions Program (CCTP) site – which has received numerous recognitions for their excellent work in care transitions. Another example is Temple University Health System, also a CCTP site, which is training and deploying community health workers to assist high-risk Medicaid patients with care transitions in an effort to reduce unplanned readmissions.

We believe these examples reflect the idea that while driving improvement through payment reduction based on measurement is an important strategy to improve care, it cannot be only approach. There need to be opportunities for hospitals to learn from other hospitals, in order to avoid unintended consequences, such as a widening of disparities or any other adverse effects on vulnerable patients.

As this program moves into its second year, we again urge the agency to use its authority to ensure that access is preserved for the most vulnerable populations. We reiterate our previous suggestion that CMS offer a one-time opportunity to waive the payment reduction for safety net and other hospitals that serve a higher-than-average proportion of low SES patients and are at risk of facing reduced payments. In return, these hospitals would be required to implement a comprehensive and aggressive preventable readmission rate improvement plan that centers on collaboratively engaging with the patients, their families, consumer organizations and community supports, and other appropriate groups to address the various factors that are causing preventable readmissions in their local community. This approach should have a time limit (e.g., six months) on how long the hospital has for submitting and implementing the plan and a another well-defined (e.g. six months) time frame for monitoring and reporting results to CMS. These hospitals can serve their patients with the highest levels of quality care and successfully implement strategies for helping patients and families manage care transitions in a way that avoids unplanned readmissions. They simply may need time to focus on this problem area. We view this as a one-time option that could drive hospitals with higher-than-average readmission rates learn from the innovative and successful strategies implemented by other institutions.

Finally, public reporting of hospital-specific readmission rates on *Hospital Compare* needs significant improvement to be more useful to consumers. Currently, readmissions are displayed as either "same as the national average," "worse than the national average," or "better than the national average. This mode of display shows little variation among hospitals and does not offer consumers and purchasers meaningful information about how well specific hospitals are performing. We recommend CMS provide more specific data on actual readmission rates when making the transition on *Hospital Compare* from reporting the IQR-based data, to reporting the data from this new readmissions reduction program.

Hospital Inpatient Quality Reporting Program (IQR)

Measures Proposed for Removal

We support the removal of the following structure and process measures, as we do not believe that they are useful quality indicators; in fact, we have requested the removal of HF-1 in the past and are very pleased to see CMS' proposal in this NPRM:

- PN-3b: Blood Culture Performed in the Emergency Department Prior to First Antibiotic Received in the Hospital
- HF-1: Discharge Instructions Measure
- HF–3: ACEI or ARB for LVSD
- IMM-1: Immunization for Pneumonia Measure (updated ACIP guidelines)
- AMI–2: Aspirin prescribed at discharge
- AMI–10: Statin prescribed at discharge
- SCIP-Inf–10: Surgery Patients with perioperative temperature management
- Structural measure: Systematic Clinical Database Registry for Stroke Care Measure

New Measures for FY 2016

We strongly support the following measures proposed for addition to the IQR for FY 2016:

- 30-Day All-Cause Risk-Standardized Readmission Rate Following COPD Hospitalization
- 30-Day All-Cause Risk Standardized Mortality Rate Following COPD Hospitalization

Adding Chronic Obstructive Pulmonary Disease (COPD) outcome measures to the IQR, and subsequently reporting the data on *Hospital Compare,* will be meaningful and useful to consumers and purchasers. In particular, we urge CMS to report these rates by gender, given that COPD mortality rates for women remained consistently high between 1999 and 2010, (according to data from the CDC) whereas the mortality rates for men have dropped in that same period.

We do not support the addition of the 30-Day All-Cause Risk Standardized Readmission or Mortality rate measures following Acute Ischemic Stroke. These measures were the subject of significant concern when reviewed by a multi-stakeholder steering committee at the National Quality Forum, and we share many of the concerns posed by that committee. We agree, however, that having data on stroke outcomes is critically important, and thus suggest that CMS include NQF Measure # 0467: *Acute Stroke Mortality Rate (AHRQ IQI 17*). This measure received endorsement from NQF in November 2012, and could provide important information to consumers and purchasers.

Finally, we strongly support implementation without delay of the following measures:

- Severe Sepsis and Septic Shock Management Bundle
- PC-02 Cesarean Section
- PC-05 Exclusive Breast Milk Feeding
- Healthy Term Newborn

In the proposed rule, CMS notes that it is eager to implement the above measures when the data can be transferred via an Electronic Health Record (EHR). While we too are eager for e-Measures in these areas, we believe that these measures are important to implement as soon as possible for their usefulness and meaningfulness to consumers, regardless of whether they are e-specified or not.

Future IQR Measures and Topics

CMS has made impressive progress in moving this program forward in ways that will lead to significant improvements in quality, as evidenced by the implementation of measures related to patient safety, care coordination, care transitions, and elective deliveries. Overall, the progression from the early portfolio of IQR measures that were mainly process-oriented, to a more outcomes- and patient safety-based set of measures will make *Hospital Compare* a more useful site for consumers and purchasers**.** We ask CMS to consider the following measures for use in the IQR which 1) reflect high volume conditions and/or procedures; 2) further the goals of the three-part aim; and 3) promote alignment between the IQR and other HHS programs, including Meaningful Use, Hospital Value-Based Purchasing, and the Partnership for Patients:

- *Medication safety measures* (all of which are part of the core requirements for Stage 1 of Meaningful Use) of universal prescription documentation and verification of current medications in the medical record; drug-drug interaction; and medication reconciliation. However, these measures need to be more than simply a checklist; consumers and purchasers

need medication safety measures that look at outcomes of adverse drug events, and not processes.

- *Surgical Outcomes Measures (other than infection rates)*, including lower-extremity bypass complications, ICU mortality and complications, elderly surgery outcomes and colorectal surgery outcomes.

- *The registry-based CABG composite score developed by the Society of Thoracic Surgeons (STS) (with the data behind the score).* Hospitals are likely to be participating in cardiac surgery registries already and thus have experience with collecting the type of data necessary for this, and other cardiac registry measures. We make this recommendation contingent on STS providing the raw data – and not just the final composite scores – to CMS in order to ensure transparency in the process.

In addition, we recommend additional measures and measure concepts for implementation and development over the coming years. Where there are specific measures already available, such as the *Potentially Avoidable Complications,* we recommend CMS put these in the IQR pipeline and the *Hospital Compare* reporting process now to allow for implementation into the Hospital Value-Based Purchasing program as soon as possible We also offer recommendations in areas where there are no NQF-endorsed measures but that have been identified by the Office of the National Coordinator for HIT (ONC) as critical to improving patient-centered care and for which efforts are being made to speed development to get them into use:

- *Potentially Avoidable Complications (PAC) Measures:* Three recently NQF-endorsed measures 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. These are important and meaningful measures that can help to improve inpatient care and assure smoother transitions through more effective coordination for three conditions that have been identified as targets for VBP. They are also intuitively understandable to consumers and purchasers.

- *Efficiency, Resource Use, and Appropriateness Measures*: We urge CMS to take a leadership role in the development of appropriateness of care measures. Conducting certain evidence-based processes well does not necessarily equate with high value care if those tests or procedures are not appropriate. Therefore, it is critical that we have appropriateness of care measures in the IQR program to create a pathway to implementation in the VPB program. One strategy would be to build measure sets around the *Choosing Wisely* campaign recommendations. These recommendations have broad-based, multi-stakeholder support and target the highest-volume/highest-cost tests and procedures.

- *Measures Related to Coronary Artery and Heart Disease (CAD and CHD):* By FY 2015, we urge CMS to expand the number of conditions to include measures related to coronary artery (CAD)and coronary heart disease CHD) and to focus on measures related to medication, angioplasty, stents, and coronary artery bypass graft (CABG). Treatment of CAD and CHD provide an opportunity for identifying and addressing appropriate use of these procedures,

particularly given the high volume and cost of stents, angioplasty and CABG performed, and the high rates of variability in quality and outcomes.

- *Measures of Patient-Reported Outcomes and Engagement:* We urge CMS to identify additional measures that use patient-reported data to assess experience of care, outcomes, including functional status. Toward that end, we encourage CMS to leverage the collaborative work it is already engaged in with the Office of the National Coordinator for HIT (ONC) and other federal partners in promoting development of measures, and adding existing measures to the quality enterprise pipeline. One example is the Patient Reported Outcomes Measure Information System (PROMIS), which provides clinicians with outcomes data across an array of domains, such as symptoms, functional status, and pain, all from the patient's own reporting of experience. PROMIS provides an excellent opportunity to employ existing tools to create patient-reported outcome measures. In addition, we urge CMS to explore ways to strengthen HCAHPS, especially in the care coordination domain and medical errors. This should include advancing activity currently underway at AHRQ to conduct focus groups with consumers about their experience of medical harm for the purposes of expanding and strengthening HCAHPS.

- *Cross-Cutting Measures of Care for Patients with Multiple Chronic Conditions*: Measures of care coordination and transitions, resource use, and appropriateness that cut *across* conditions are critically needed to determine how well care is being provided to patients with multiple chronic conditions. We urge CMS to take a leadership role in tying payment to measures that will address the needs of the highest-cost and most vulnerable populations within our system.

Hospital Value-Based Purchasing Program (HVBP)

The HVBP program's goal is to foster rapid improvement, by tying payment to high quality performance, and creating a market that recognizes and rewards quality. As this program matures, we believe it should support ongoing improvement and gradually raise the bar by tying an increasing portion of hospitals' payment to performance. Thus, we continue to urge CMS to implement measures in this program for which 1) there are clear gaps in hospital performance; and 2) reflect the categories of care that are most meaningful to consumers and purchasers, such as, outcomes, functional status, care coordination and transitions, and patient experience. Overall, the changes outlined in the proposed rule reflect these recommendations.

We support CMS' proposal to, and rationale for, removing the following three measures from this program:

- AMI-8a: Primary PCI Received within 90 Minutes of Hospital Arrival
- PN-3b, Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
- HF-1 Discharge Instructions

In addition, we recommend CMS consider remove the following measure:

- Post-Operative Urinary Catheter Removal on Post-Op Day 1 or Day 2: A more meaningful measure for holding hospitals accountable for providing high quality care is incidence of Catheter-Associated Urinary Tract Infection (CAUTI), which is NQF-endorsed and slated for implementation in the Inpatient Quality Reporting Program. Last year's HVBP proposed rule

stated that this process measure of post-operative urinary catheter removal is important because it can reduce CAUTI, but a measures of the rate of CAUTI in the hospital is more meaningful. If this measure is not removed, we recommend that CMS pair it with the complimentary CAUTI rate measure once that has been reported on Hospital Compare for the requisite 12 months and thus eligible for use in the HVBP.

Other Proposed Changes to the HVBP for FY 2016

We strongly support the inclusion of the following outcome measures in the HVBP program:

- Catheter-Associated Urinary Tract Infection rate: As noted above in the discussion of "Post-Operative Urinary Catheter Removal on Post-Op Day 1 or 2," the most meaningful measure of whether patients are receiving safe, high quality care that will reduce the occurrence of healthcare-acquired conditions is to look at outcomes, not processes.

- Central-Line Associated Blood Stream Infection rate: we have urged the inclusion of this measure across CMS hospital programs, and believe adding it to the HVBP will have a significant impact on patient safety outcomes.

- Influenza Immunization: We strongly support health care worker vaccinations in the context of patient safety and believe that there is significant room for improvement in terms of rates of influenza immunization.

- Surgical Site Infection for Colon and Abdominal Hysterectomy: Overall, adding SSI measures to the HVBP program will only strengthen its ability to drive high quality care for all consumers. The field is still learning about the range and risk in variation in SSIs, and this is an opportunity to better understand that risk as well as to improve care for patients undergoing high volume colon and hysterectomy procedures. In addition, evidence shows that abdominal hysterectomy SSI rates are a strong signal for what the predicted SSI rate may be as it relates to other procedures.

In addition to these measures that were described in the proposed rule, we urge CMS to include the following measures to the outcomes domain of the HVBP:

- MRSA
- c-diff
- Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)
- 30-Day All-Cause Readmission Rate Following Elective Primary Total Hip Arthroplasty and Total Knee Arthroplasty

Particularly for the THA and TKA measures, we feel these are important outcome indicators for consumers who experience these high cost, high volume procedures. Because hip and knee replacements are often non-emergent procedures, information on outcomes will give consumers an opportunity to research the quality of care provided in their local hospitals. Their addition would create a strong suite of hip and knee replacement-related measures, complimenting those in the IQR, the readmission measures being proposed for the readmission reduction program, and the HAC measures that we suggest for the HAC non-payment program in this area.

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

The Affordable Care Act's establishment of a quality reporting program for PPS-exempt Cancer Hospitals (PCHs) reflects the need for accountability and improvement of quality for consumers who require cancer care. Medicare spends more than eight billion dollars annually on inpatient cancer care (not including chemotherapy which is covered under Part B). This does not address the enormous additional non-clinical costs felt by family and other caregivers, community supports, and productivity loss.

We support the proposed addition in FY 2015 of the Surgical Site Infection measure. CMS is, however, also proposing the inclusion of a long list of process measures which we do not support. Moving forward, we urge the agency to drive this program as it has the IQR, by implementing fewer process measures and focusing more on outcome measures. In particular, we recommend that CMS develop measures of particular relevance to this program, such as measures of risk-adjusted, stage-specific survival curves for various types of cancer (e.g., lung, pancreas, liver, thyroid and esophagus, breast, colorectal). We would point out that these survival rate measures would not need to be developed "from scratch," as they are currently being used already in clinical trials and academic publications. They would, however, need to be adopted by a measure steward for the purposes of validation, testing, and NQF endorsement. We would ultimately want to see these measures be required for public reporting by any organized cancer center, irrespective of whether care is provided on an outpatient or inpatient basis.

Finally, we strongly support the inclusion of the HCAHPS survey for FY 2015. We have long advocated for HCAHPS to be a required element of every hospital pay-for-reporting program, to ensure that the experiences of patients across all institutions are assessed and considered.

Long-Term Care Hospital Quality Reporting Program (LTCHQR)

We strongly support CMS' proposal to include MRSA, c-diff, and a 30-day readmission rate measure in the LTCHQR program. These are critically important measures to long-term-care hospital patients, and we question the rationale behind delaying implementation until FY 2017 as it notes in the NPRM.

In addition, we support many of the proposed measures and topics being considered for the future of the program but are disappointed at the lack of discussion of how to fill the measure gaps for this setting, as recommended by the Measure Applications Partnership (MAP) Long-Term Care/Post-Acute Care Workgroup in 2012. We strongly supported the high-leverage measure concepts recommended by the MAP workgroup in its report to HHS, including Experience of Care, Care Planning, Implementing Patient/Family/Caregiver Goals, and Avoiding Unnecessary Hospital and ED Admissions. We understand that there are significant measure gaps for this particular setting, but urge CMS to take the lead in identifying hospital, nursing home, hospice, and palliative care measures that would be appropriate for the long-term care hospital setting, and work with measure developers to allow for these measures to be applied to patients in long-term care hospitals. The highest priority for this work would be the CAHPS survey, which is available for the inpatient, nursing home, and home health settings. Another would be the Care Transition Measure 3-question Survey, which is already being proposed for the IQR. Additional priorities include measures on SSIs, sepsis, depression assessment and management, functional change, and pain management.

Finally, we urge CMS to publicly report the LTCHQR data on *Hospital Compare*. The proposed rule notes that there are no proposed procedures or timelines currently established for public reporting of these data which we believe this does not reflect the commitment to accountability and transparency evidenced by the other programs referenced in this letter.