Consumer-Purchaser
DISCLOSURE PROJECT
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June 25, 2012

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

RE: CMS-1588-P: Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and FY 2013 Rates and to the Long Term Care Hospital PPS; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers

Dear Ms. Tavenner:

The 30 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 rule for the Medicare Inpatient Prospective Payment System (IPPS). The detailed comments that follow this letter pertain to the following sections of the Notice of Proposed Rule Making (NPRM):

- II. F. Preventable Hospital-Acquired Conditions (HACs), Including Infections
- IV. A. Hospital Readmissions Reduction Program
- VII. A. Hospital Inpatient Quality Reporting Program (IQR)
- VII. B. Hospital Value-Based Purchasing Program (HVBP)
- VII. C. PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- VII. D. Long-Term Care Hospital Quality Reporting Program (LTCHQR)

We have supported the goals and operationalization of the Inpatient Quality Reporting (IQR) program since it began in FY 2005. We appreciate the direction that CMS is taking the program, essentially transforming it from a set of discrete process measures oriented toward internal quality improvement, to a comprehensive program that addresses the needs of consumers and purchasers by including meaningful measures of outcomes, patient experience, and patient safety. We commend CMS' efforts to improve patient safety, foster increased transparency, and promote a market that recognizes and rewards quality rather than volume. As the delivery system continues its move in this direction, we are pleased to see the enhancement of the IQR, which is using quality metrics to identify and drive better health, better care, and lower costs.

Although we support the overall direction of the proposed rule, we would like to see more attention be paid to alignment with other purchasers' value-based efforts. These purchasers include those in the private sector, as well as states, which serve as high-volume purchasers for their public employees and

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Medicaid enrollees. Considerable effort is being made by multiple stakeholders to drive private and state purchasers in this direction. While these efforts are having an impact and are expanding, there is still only a small percentage of health coverage being purchased by employers using "value-based" criteria. For private purchasers, this often means applying quality measures to hold health plans accountable, whereas for states it may mean using metrics to ensure that the public employee and Medicaid health plans are contracting with the highest value providers.

We urge CMS – in all of its payment programs – to develop a parsimonious list of high-impact measures suitable for both private and public purchasing. Doing so would require working closely with private and state purchasers during pre-rulemaking, including the Measure Applications Partnership (MAP). For example, in our comments below, we strongly support implementation of the proposed measure, "*Elective Delivery Prior to 39 Weeks*" in the IQR. It sends a clear signal that CMS recognizes the importance of using measures that go beyond the Medicare population and reflect the quality concerns of the private purchasers as well as states that are facing extreme financial challenges related to Medicaid. The public-private alignment concept goes beyond the IQR, and is reflected in many of the initiatives CMS, HHS and other federal agencies have put forward in the National Quality Strategy, as well as the Meaningful Use of Health IT incentive program. We need all purchasers to work together to send a strong signal to the market about the importance of "rowing in the same direction," using aligned priorities. This will ultimately enable providers to focus on improvement, rather than on fulfilling multiple, disparate measurement requests. We look forward to working with CMS and other partners as we seek alignment on these and related programs

Overall, we applaud the various proposals put forward for the programs listed above. Our comments focus broadly on the following:

- **We support CMS' drive toward pay-for-reporting and pay-for-performance measures that meet the "better care-better health-lower cost" priorities of the National Quality Strategy's three-part aim.** In this proposed rule, CMS succeeded in identifying measures that fall into the six NQS domains of clinical care, person-and-caregiver-centered experience and outcomes, safety, efficiency and cost reduction, care coordination, and community/population health.

- **We support the continued addition of measures that will improve patient safety and align with other public and private sector efforts.** We welcome the proposed addition of two new Hospital-Acquired Conditions (HACs) to the Medicare non-payment program, as well as the addition of the AHRQ *Patient Safety for Selected Indicators* (PSI-90) composite measure in the Hospital Value-Based Purchasing Program. Patient safety measures are meaningful and usable by consumers and purchasers, and allow all stakeholders to address the clinical and care coordination gaps that lead to poor outcomes.

- **However, we caution against removing granular patient safety information entirely from the IQR program.** We accept CMS' rationale for removing certain AHRQ Internal Quality Improvement (IQI) and Patient Safety (PSI) Indicators, given their redundancy with already-implemented composite measures of quality and safety. In our comments we recommend CMS do whatever is necessary so that all stakeholders can continue to drill down on *Hospital Compare* to access information on specific conditions and procedures.

- **We applaud the proposed inclusion of measures of care coordination and outcomes in the IQR Program that have significance for all consumers, not just those who are covered under Medicare.** As discussed above, we commend CMS driving the portfolio of programs administered via the IPPS to be more aligned with what private sector purchasers and payers are doing to improve care and reduce costs. We are encouraged by the proposed inclusion of measures such as *Elective Deliveries Prior to 39 Weeks Gestation.* We also support the proposed inclusion of the Care Transition Measure (CTM-3), which will provide much needed information about care coordination.

- **We believe that applying measurement and financial incentives to solve the problem of high preventable readmission rates is directionally appropriate, as long as it is implemented in such a way that does not lead to reduced access to care, particularly for the most vulnerable patients.** In our comments below, we ask CMS to consider allowing safety net and other hospitals that serve vulnerable populations to develop a method for letting these hospitals commit to creating and implementing programs for collaboratively engaging with their communities to reduce preventable readmissions, without initially experiencing a payment reduction.

- **Wherever possible, CMS should collect and report data on *Hospital Compare* in a way that can be stratified by race, ethnicity, language, and gender (RELG).** Having data that can be identified by RELG 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 IPPS regulations. 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
AFL-CIO
Alliance for Safety Awareness for Patients
American Benefits Council
American Federation of State, County & Municipal Employees (AFSCME)
American Hospice Foundation
Buyers Health Care Action Group
Center for Patient Partnerships
Childbirth Connection
Consumers Union
Dallas-Fort Worth Business Group on Health
Employers' Coalition on Health

Healthcare 21 Business Coalition
Health Watch USA
Health Policy Corporation of Iowa
Iowa Health Buyers Alliance
Lamaze International
Maine Health Management Coalition
Mothers Against Medical Error
National Business Coalition on Health
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Pacific Business Group on Health
PULSE
St. Louis Business Health Coalition
SEIU
Texas Business Group on Health
The Alliance
UNITE HERE Health

ADDENDUM: DETAILED COMMENTS ON IPPS NOTICE OF PROPOSED RULEMAKING, FY 2013

II. F. 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, or in other words, not "present on arrival" when a patient entered a hospital for any reason. Ten *Serious Reportable Events* were selected for this program, including object left in after surgery, air embolism, blood incompatibility, catheter-associated urinary tract infection (CAUTI), stage III and IV pressure ulcer, vascular catheter-associated infection, poor glycemic control, deep vein thrombosis (DVT) or pulmonary embolism (PE) following total knee replacement or hip replacement, and certain falls and trauma. We agree with CMS that these HACs satisfy the 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.

We support CMS' proposal to expand this program with the addition of two HACs: 1) surgical site infection (SSI) following cardiac implantable electronic device (CIED) procedures; and 2) iatrogenic pneumothorax with venous catheterization. In prior years we have urged CMS to expand the Inpatient Quality Reporting (IQR) program to include additional surgical site infection HACs, as well as a measure of iatrogenic pneumothorax. Given the proposed removal of the HAC rates from the IQR (see our comments below), we are pleased that these HACs are being proposed for the non-payment program. In addition, we firmly support reporting the HAC rates on the *Hospital Compare* website in order to retain the high level of transparency that was achieved last year when these data were first publicly reported and urge CMS to retain this provision in the final rule**.** It is CMS' continued commitment to publicly report this critical information on *Hospital Compare* that makes the elimination of the HACs from the IQR somewhat more palatable to consumers and purchasers.

Finally, we recommend CMS expand this program further by adding SSIs for cesarean section surgery, hip replacement and knee replacement surgery. These procedures are widely recognized as being both high volume and high cost. In the case of cesarean section, CMS recognizes the cost of perinatal and post-partum care related to caring for the dual eligible population, as evidenced by the proposed elective delivery measure in the IQR. In addition it recognizes the risk to patients during hip and knee surgeries, as reflected by the DVT/PE HAC in the list above. We believe that the addition of these SSIs to the data already collected would add significant value to the program for this patient population to the program.

IV. A. Hospital Readmissions Reduction Program

The Affordable Care Act established the Hospital Readmissions Reduction Program in order to address the high rates of preventable hospital readmissions. Starting in FY 2013, hospitals will be assessed based on their 30-day risk-adjusted readmission rates for patients with Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia (PN). Hospitals that perform better than the average hospital that admitted similar patients (i.e., similar age and comorbidities) will not experience reductions in their base DRG payments. However, hospitals that perform worse than the average hospital with similar patients will see a payment reduction up to 1 percent of their base DRG. Depending on the readmission rate a hospital will fall into one of ten deciles, with each decile experiencing some percentage payment reduction between 0.1 to 0.99.

As we commented in last year's rulemaking cycle, we also support the use of the three NQF-endorsed risk-adjusted readmission rate measures, which adjust for patient demographic factors, coexisting medical conditions and indicators of patient frailty, and exclude planned readmissions and transfers to acute care facilities. By linking financial incentives to standardized quality metrics, we believe that this program – which aligns the IPPS with the goals of the *Partnership for Patients* – will drive significant improvement in patient outcomes and reduce unnecessary costs to the system.

The proposed rule offers data on the readmission rates at hospitals that serve the highest percentage of low socio-economic status (SES) patients, and indicates that 1) not all of these hospitals would experience a payment reduction; and 2) of those that do experience a reduction, a low percentage of those would experience the full one percent reduction. While this is somewhat reassuring, we cannot deny the current data that indicate safety net hospitals and other hospitals that serve disproportionately high percentages of low SES patients see a higher-than-average rate of unplanned readmissions. We also recognize the data that show a strong correlation between the lack of family and community supports and the probability of an unplanned hospital readmission. While driving improvement through payment reduction based on measurement is an important strategy to improve care, it cannot be the only piece. Clearly, we do not want a program designed to improve patient outcomes to widen disparities or in any way adversely impact the care of vulnerable patients.

We know that CMS must follow the statutory framework laid out in the ACA. However, we urge the agency to use its authority where possible to ensure that access is preserved for the most vulnerable populations. One suggestion for how to accomplish this is to 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 found to be at risk of experiencing a payment reduction. In return, these hospitals would be required to submit a comprehensive and aggressive preventable readmission rate improvement plan that centers on collaboratively engaging with the patients, their families, consumer organizations and community supports, 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 another well-defined (e.g. six months) time frame for monitoring and reporting results to CMS. Again, we view this as a one-time option that could drive hospitals with higher-than-average readmission rates to look to, and emulate, the innovative and successful strategies implemented by similar institutions, and not an on-going opportunity to waive performance on readmissions by safety net hospitals.

This recommendation does not belie our belief that hospitals should be held accountable for doing everything possible to reduce preventable readmissions; it simply acknowledges the challenges facing safety net hospitals and consumers who rely upon them, and offers a pathway to improvement that involves collaborating with consumers, patients, families, and the community at large.

Finally, public reporting of hospital-specific readmission rates on *Hospital Compare* needs significant improvement. Currently, readmissions are displayed as either "same as the national average," "worse than the national average," or "better than the national average. This shows little variation among hospitals and does not offer to 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.

VII. A. Hospital Inpatient Quality Reporting Program (IQR)

Measures Proposed for Removal

CMS clearly understands the urgency of improving the safety of our nation's hospitals, as reflected by the launch of the *Partnership for Patients* initiative. We need a strong a set of patient safety measures to form the cornerstone for achieving the *Partnership for Patients* goals, and applaud CMS for finalizing such measures as Catheter-Associated Urinary Tract Infection (CAUTI) and Central-Line Associated Blood Stream Infection (CLABSI) in the IQR. However, we are disappointed by the proposed removal of some of the hospital-acquired condition (HAC) measures from the program, as well as the removal of the eight AHRQ quality improvement and patient safety indicators. .

Where HACs are redundant with other implemented measures (as is the case with CAUTI and CLABSI) we do not oppose removing the HAC. However, in the case of other events such as falls and trauma, foreign object retained after surgery, manifestation of poor glycemic control, and vascular catheter-associated infections, we believe that the concerns expressed by some hospitals are insufficient to warrant their removal from reporting and payment programs. For example, some have stated that publicly reporting certain measures on *Hospital Compare* could potentially mislead or confuse consumers due to irregularities in the coding of data used to calculate these rates. While we certainly share the need to improve coding practices, these technical issues are not new. We urge CMS to work with appropriate stakeholders to address these concerns, rather than allow them to delay urgently needed safety improvements or worse, serve as a rationale for eliminating valuable information already being publicly reported.

As an alternative to removing non-redundant HACs from reporting or payment programs, we recommend those measures that generated concern be considered "interim," while CMS engages in efforts to develop measures that address these issues. As we noted earlier in our comments on the HAC non-payment program, we strongly support CMS' intention to continue publicly reporting *all* the HACs on *Hospital Compare*, and recognize that this mitigates some of our objections and concerns regarding transparency in this area. Nonetheless, with the removal of the HACs, there is still the concern regarding them being "lost" when it comes to the Hospital Value-Based Purchasing pipeline.

Regarding the following eight AHRQ measures proposed for removal:

- IQI-11: Abdominal aortic aneurysm (AAA) repair mortality rate
- IQI-19: Hip fracture mortality rate
- IQI-91: Mortality for selected medical conditions (composite)
- PSI-06: Iatrogenic pneumothorax
- PSI-14: Postoperative wound dehiscence
- PSI-15: Accidental puncture or laceration
- PSI-11: Postoperative respiratory failure
- PSI-12: Postoperative PE or DVT

We are not opposed to the removal of these measures since they are – for the most part – included in the AHRQ Patient Safety for Selected Indicators (PSI-90) Composite measure (for which we offer additional comments below related to the Hospital Value-Based Purchasing program). However, we are concerned that eliminating the fact that make up a clinical care composite could have detrimental effects on CMS' efforts to publicly display composite measures in a way that allows stakeholders to "drill down" and access more granular information on the individual measures. We would appreciate if the final rule confirmed that transparency of information on these safety events is not compromised by the removal of these measures.

Finally, we support the proposed removal of measure SCIP-VTE-1, *Surgery Patients with Recommended VTE Prophylaxis Ordered*, which we recommended during last year's rulemaking cycle. In addition to this measure, we suggest that CMS also drop the following measures from both the IQR and subsequently, from the Hospital Value-Based Purchasing Program:

- HF-1 (Discharge Instructions): Measuring and holding hospitals accountable for high quality, effective transitions for patients at discharge is a significant priority for consumers and purchasers. However, we do not feel that this particular measure adequately accomplishes this goal. It is an example of a "check the box" measure, which does not convey meaningful or actionable information about the quality of the discharge process. We also note that if an element of the Meaningful Use Stage 2 proposed rule is finalized, hospitals will be required to provide online access to a much more robust set of information about hospital stay and discharge, which would make this measure even less relevant.

- SCIP Infection-2 (Prophylactic Antibiotic Selection for Surgical Patients): The implementation in FY 2014 of a surgical site infection rate measure that provides meaningful outcomes information, makes it is unnecessary to include this process measure in the IQR requirements.

New Measures for FY 2015 and 2016

We strongly support the following measures proposed for addition to the IQR for FY 2015 and 2016:

All-condition, All-Cause Readmission: While disease-specific measures of readmission are useful in identifying deficiencies in care for specific groups of patients, they account for only a small proportion of total readmissions. By contrast, a hospital-wide readmission measure portrays a broader sense of the quality of care in hospitals, promotes hospital quality improvement and better informs consumers about care quality. The overall goal should be to reduce – to the extent feasible – the readmissions that result from poor quality of care or inadequate transitional care. These reductions can come about through improvement in communications with patients and their caregivers and ambulatory care providers; strict attention to patient safety and elimination of medical errors; and strong care transition and discharge protocols. Having discrete process measures of these types of activities may not be feasible nor are they desirable. Instead, an all-condition, all-cause readmission index will provide hospitals with data that will allow them to look at all facets of their hospital operations and identify where the breakdowns in care and communication are occurring.

Care Transition Measure 3-Question Survey (CTM-3): We have proposed this measure for inclusion in the IQR in previous rulemaking cycles and are extremely pleased to see it included in the Measure Applications Partnership (MAP) recommendations to HHS, as well as in the proposed rule. The CTM-3 provides much-needed supplementary information to stakeholders on how patients and their families experienced communications during the critical hospital discharge care transition period. Evidence indicates that care transitions have a significant correlation with readmissions; thus, identifying the communication gaps can help hospitals address problems with discharge and care transitions so that they can improve these processes.

Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA); and *30-Day All-Cause Readmission Rate Following Elective Primary Total Hip Arthroplasty and Total Knee Arthroplasty*: These measures are important outcome measures for consumers who experience these high cost, high volume hip and knee replacement 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.

Elective Delivery Prior to 39 Completed Weeks Gestation: As noted earlier, we strongly support this measure. In addition to aligning priorities across the public and private sectors, it aligns with the *Strong Start* initiative, as well as with the priorities of the National Quality Strategy and the efforts of the National Priorities Partnership. Elective deliveries prior to 39 weeks pose risk of complications to the mother and baby, are correlated with long-term health problems, and potentially pose significant costs to the system that are borne by consumers, purchasers, and payers, the latter two across both public and private sectors. As with hip and knee replacement, labor and delivery is an event for which women have the opportunity to make decisions based on their personal preferences, making this measure enormously meaningful and useful to a large and important group of health care consumers.

For the FY 2015 and 2016 IQR, we have serious questions and concerns about the following:

Inclusion of two "About You" questions to the HCAHPS Survey: CMS proposes to add two questions to the HCAHPS survey that would not be reported on Hospital Compare, but rather, would be used by CMS to stratify HCAHPS responses. These questions are:

- During this hospital stay, were you admitted to the hospital through the emergency room? (yes/no)
- In general how would you rate your overall mental or emotional health? (excellent/very good/good/fair/poor)

We have significant concerns about these questions. The proposed rule does not provide enough information on the relationship between either how a person entered the hospital, or one's mental health status, to overall HCAHPS responses. We would like additional information on, and better understanding of: 1) the validity and reliability of adding them; 2) what value they bring to HCAHPS; and 3) whether their inclusion has been tested, and, if so, what were the findings. We urge CMS to delay adding these questions until these concerns can be more thoroughly addressed.

Limiting CLABSI and CAUTI Measures to the Intensive Care Unit: We strongly supported the inclusion of the CLABSI and CAUTI measures in last year's IPPS final rule. However, we ask for further explanation as to why are these measures only going to be applied to the ICU population when have been re-specified by the measure developer to apply broadly across the inpatient setting. Central Line-Associated Blood Stream Infections and Catheter-Associated Urinary Tract Infection measures are extremely important to identifying patient safety gaps, and they occur across inpatient departments. As the Measure Applications Partnership (MAP) strives to address patient safety events across patient care settings, we urge CMS to broaden the scope of the population for whom these measures will apply and be reported on in *Hospital Compare.*

Future IQR Measures and Topics

Over recent years, CMS has moved 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 that will make *Hospital Compare* a more useful site for consumers and purchasers has been remarkable**.** The focus solely on tobacco and alcohol measures in the section on future measure topics does not reflect this forward progression, however. Thus, we ask CMS to instead consider the following measures in 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 documentation and verification of current medications in the medical record; drug-drug interaction; and medication reconciliation

- *Surgical Outcomes Measures*, 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). Hospitals are likely already to be participating in cardiac surgery registries and have experience with collecting the type of data necessary for this, and other cardiac registry measures.

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 rapid implementation into the Hospital Value-Based Purchasing program. 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 either 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 not only inpatient care, but also care coordination and transitions 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.

- *Measures Related to Coronary Artery and Heart Disease (CAD and CHD):* We urge CMS to expand the number of conditions reflected in the program by FY 2015 to include measures related to coronary artery and coronary heart disease 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, and 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 and/or pushing already-existing measures into 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. In addition, we urge CMS to explore ways to strengthen HCAHPS, especially in the care coordination domain as well as adverse events. This should include advancing activity currently underway at AHRQ to conduct focus groups with consumers about medical harm events for the purposes of expanding the HCAHPS tool.

- *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.

VII. B. Hospital Value-Based Purchasing Program (HVBP)

It is critical that the HVBP program foster rapid improvement by tying payment to high quality performance, and promoting a market that recognizes and rewards quality. We believe that as this program matures, an increased portion of hospitals' payment should be tied to performance on measures that reflect whether patients are receiving care that is consistent with the priorities of the National Quality Strategy. 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 both the SCIP-INF-10 measure (*Surgery Patients with Perioperative Temperature Management*) and the SCIP-VTE-1 (*Prophylaxis for VTE Ordered)* from the Hospital Value-Based Purchasing Program. In addition to being "topped out" as SCIP-INF-10 has been deemed to be by CMS, we feel that these are both examples of process measures that do not have a strong linkage to outcomes**.** In addition to removing these two measures, we recommend removing the following three process measures as well (note the first two measures were discussed above in the IQR comment section):

- *HF-1: Discharge Instructions*: Measuring and holding hospitals accountable for high quality, effective transitions for patients at discharge is a significant priority for consumers and purchasers. However, we do not feel that this particular measure adequately accomplishes this goal. It is an example of a "check the box" measure, which does not convey meaningful or actionable information about the quality of the discharge process. As noted earlier in our comments, we urge CMS to finalize the Care Transition Measure (CTM), so that it can be considered for HVBP.

- *SCIP-INF-2: Prophylactic Antibiotic Selection for Surgical Patients*: This process measure is not strongly linked to outcomes. We believe it should be removed, and replaced with a surgical site infection rate measure that will be implemented in the IQR program in FY 2014.

- *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 the rate of CAUTI in the hospital is overall 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

We strongly support the proposed addition of two critical patient safety measures: the *AHRQ Patient Safety for Selected Indicators Composite (PSI-90)*, and the measure of *Central Line-Associated Blood Stream Infection (CLASBI)* in FY 2014. As noted above in our comments on the IQR, composite measures such as PSI-90 are often more meaningful for consumers and purchasers. If the individual measures that comprise this composite are removed from the IQR, it would make them ineligible for consideration in the HVBP, making this composite measure all the more critical to retain. Regarding CLASBI, 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.

While we are disappointed by the delay in implementing the Medicare Spending per Beneficiary measure, we understand the statutory rationale. We continue to fully support this measure as an initial indicator of efficiency, and look forward to its implementation in FY 2015.

Finally, we strongly support CMS' proposal for how the value scoring will be weighted beginning in FY 2015. We urge CMS to retain the 30 percent weight for patient experience, given that patient experience is a critically important dimension of quality, and as such, must remain a significant indicator of overall hospital performance. Further, we strongly support weighing outcome measures at 30 percent, efficiency at 20 percent, and process measures at 20 percent. During last year's rulemaking cycle we recommended that CMS make room for outcome measures by reducing the weight assigned to process measures, and we appreciate that that is reflected in the current proposed rule.

VII. C. 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). And that does not begin to address the enormous additional non-clinical costs felt by family and other caregivers, community supports, and productivity loss. We firmly support the implementation of both the CAUTI and CLABSI measures in the first year of the program, and appreciate the attention being paid to infection rates which are very prevalent for cancer patients.

CMS is also proposing implementation of three cancer-specific measures related to breast and colorectal cancer:

- Adjuvant chemotherapy is considered or administered within 4 months of surgery to patients under the age of 80 with AJCC III colon cancer

- Combination chemotherapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC T1c or stage II or III hormone receptor negative breast cancer

- Proposed Adjuvent hormonal therapy (for women 18 years or older who have a first diagnosis of breast cancer at AJCC T1c or Stage II or III whose primary tumor is hormone receptor positive.

We agree that breast and colorectal cancers are an appropriate place to begin this program, given the high volume of patients and high costs of care. While we are generally not in favor of using process measures, these three measures are supported by evidence that links them strongly to outcomes. However, in the end, it is outcome measures that cancer patients and their families are most concerned with. We strongly urge CMS to look beyond process measures and support the development of measures that provide much-needed data on risk-adjusted, stage-specific survival curves for various types of cancer, and at various stages in the disease. These measures should be reported in three ways: 1) stage; 2) overall survival (OS); and 3) disease-free survival (DFS). In addition to colorectal cancer, consumers need these measures for lung, pancreas, liver, and esophagus in terms of 5 year survival. Breast cancer survival curve measures should be specified in terms of 10 year survival rates, and thyroid cancer according to 20-25 year survival rates.

Finally, we strongly support the proposal to publicly report these measures on *Hospital Compare*. This will create one central location for consumers and purchasers to find standardized quality information, regardless of condition or procedure for which they need care.

VII. D. Long-Term Care Hospital Quality Reporting Program (LTCHQR)

We support the measures laid out for FY 2014, 2015 and 2016 for this program, including Catheter-Associated Urinary Tract Infection, Central Line-Associated Blood Stream Infection, and New or Worsened Pressure Ulcers.

However, we are disappointed at the lack of discussion of how to fill the measure gaps for this setting, as per the recommendations made by the Measure Applications Partnership (MAP) Long-Term Care/Post-Acute Care Workgroup. We strongly supported the high-leverage measure concepts recommended by the 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.

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 is inappropriate and does not reflect the commitment to accountability and transparency evidenced by the other programs referenced in this letter.