Consumer-Purchaser
DISCLOSURE PROJECT
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June 20, 2011

Donald Berwick, MD, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS-1518-P: Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and FY 2012 Rates and to the Long Term Care Hospital PPS and FY 2012 Rates

Dear Dr. Berwick:

The 30 undersigned consumer, purchaser, and labor organizations appreciate the opportunity to submit comments to CMS on the proposed rule for the Inpatient Prospective Payment System (IPPS), focusing specifically on the Inpatient Quality Reporting (IQR) Program. The IQR, in existence since FY 2005, is a solid foundation upon which future hospital value-based purchasing programs will be built. CMS' commitment to transforming the program from a set of discrete process measures to one that addresses the needs of consumers and purchasers by including meaningful measures of outcomes, patient experience, and patient safety is evident in the proposed rule.

We commend CMS' continued efforts to foster increased transparency and promote a market that recognizes and rewards quality rather than volume. These concepts have now expanded beyond the IQR, and are reflected in many of the initiatives mandated by the Affordable Care Act (ACA), as well as the Meaningful Use of Health IT incentive program. We look forward to working with CMS and other partners as we seek alignment on these related programs.

Our comments pertain to issues raised in the section of the proposed rule on the Inpatient Quality Reporting (IQR) Program:

- **Overall, we support all the proposed clinical measures for FY 2014 and FY 2015:** We strongly support the commitment CMS has demonstrated in this proposed rule to add four additional hospital-acquired infection (HAI) measures. Adding these HAIs will bring the IQR in line with the recommendations made in the 2009 *HHS Action Plan to Reduce Hospital-Acquired Infections*[1], and pave the way for the introduction of these measures into the Hospital Value-Based Purchasing program. They will also support the work of the federal government and private stakeholders in the *Partnership for Patients* program.

- **We support the addition of cost and efficiency measures into the IQR, and provide recommendations for improving the proposed *Medicare Spending per Beneficiary:*** We strongly support the addition of measures – for public reporting and for payment– related to efficient use of health care resources. We provide suggestions to improve the measure's capacity to achieve appropriate goals.

[1] http://www.hhs.gov/ash/initiatives/hai/infection.html

Pacific Business Group on Health
221 Main Street, Suite 1500, San Francisco, CA 94105
415.281.8660 | tel

National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650, Washington, DC 20009
202.986.2600 | tel

- **Wherever the infrastructure for data collection already exists, we urge CMS not to delay measure implementation until FY 2015:** For many of the FY 2015 measures proposed – including the HAIs, stroke and VTE sets – the infrastructure for data collection and hospital review already exists across the country. We urge CMS to begin collecting data for measures in 2012 to allow for implementation in FY 2014 for payment determination and reporting on *Hospital Compare.*

- **When available, we prefer using measures that have been endorsed by the National Quality Forum (NQF).** In general, we are not in favor of CMS seeking endorsement of measures through other consensus bodies. NQF-endorsed measures have undergone careful evaluation by a consensus body that has been working collaboratively and effectively for a number of years. We do not believe that it would be constructive to circumvent the NQF when so much energy and attention has been devoted to create an environment of trust and goodwill among the stakeholders. NQF-endorsed measures are most likely to be acceptable to the widest number of stakeholders, which is important to ensure the credibility of the IQR program as well. If CMS uses a measure in the IQR program that has not been NQF-endorsed, we urge the measure be submitted for expedited review.

Measure "Rotation" and Retirement

We continue to support CMS' proposal to retire the eight measures noted in last year's IPPS final rule. We do, however, want to reiterate the need for CMS to address more comprehensively the criteria for measure retirement. The criteria outlined in the FY 2010 final rule stated that retirement would be considered for measures where performance has "topped out," and where measures which have led to unintended consequences.

In situations where performance on clinical measures has reached close to 100 percent compliance, consumers and purchasers may still be interested in seeing comparative information. This conflicts, however with the need to make room for new, more meaningful, measures. **We again suggest that CMS develop a method for rotating certain "topped out" measures, whereby these measures would still be collected and reported but not on an annual cycle (e.g., every three years), to ensure that quality in these areas does not "slip."** In the FY 2010 Final IPPS rule, CMS noted that it does not have a mechanism for conducting ongoing surveillance of measures that are retired, but was committed to exploring options for monitoring whether the performance on retired measures deteriorates over time. We suggest that requiring periodic reporting could be a piece of the solution.

The rotation model suggested above would also address our related concern regarding the retirement of process measures that may be part of a composite measure. Composite measures, conveying layered information about performance of clinical processes for a given condition or procedure, will help make the information on *Hospital Compare* more useful for consumers and purchasers. The elimination of measures that may make up a clinical care composite could have detrimental effects on CMS' efforts to publicly display composite measures; thus we appreciate CMS' thoughtful consideration of this issue.

Finally, in addition to the eight measures slated for retirement, we also recommend retirement of the following measures:

- *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 do not convey meaningful or actionable information about the quality of the discharge process. We strongly urge CMS to

implement a more robust measure across conditions, such as the Care Transition Measure (CTM) detailed later in this letter. The CTM assesses the quality of the care transition communication that occurred between the provider, the patient, and her family/caregiver, from the patient's perspective.

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

- *SCIP-VTE-1 (Surgery patients with recommended VTE prophylaxis ordered) and SCIP-VTE-2 (Surgery patients who received appropriate VTE prophylaxis within 24 hours pre/post-surgery)*: These two measures reflect whether a venous thromboembolism (VTE) prophylaxis was 1) ordered and 2) received and will be redundant if the VTE measure set proposed for FY 2015 is implemented. At the very least, the current measures should be harmonized with the VTE measures, and combined into a composite measure, to make data transmission from the hospital to CMS more efficient.

FY 2014 Measures

Based on the proposed rule, we believe beginning in FY 2014, IQR will be substantially strengthened and improved due to the emphasis on patient outcomes and patient safety. We commend CMS for adding – in accordance' with last year's IPPS final rule – measures of central line-associated blood stream infection (CLABSI) and surgical site infection (SSI). **And we strongly support the addition of measures of central line bundle compliance and catheter-associated urinary tract infection**. Implementing these measures will not only help meet the goals of the 2009 *HHS Action Plan to Prevent Hospital-Acquired Infections*, but also will align this inpatient program with the goals of the National Quality Strategy in general, and the *Partnership for Patients* in particular. Additional thoughts on the importance of HAI measures are provided in the section below regarding FY 2015 measures.

We also support the measure of "Participation in a Systematic Clinical Database Registry for General Surgery." Clinical registries will continue to be a key source of information for the development of longitudinal measures for tracking patient care and outcomes. However, we note that measuring which hospitals are participating in such registries is only the first step in a much-needed pathway toward collecting longitudinal clinical data and making it useable by patients and payers. We strongly urge CMS to consider adding measures based on registry-data, such as the composite measure on Cardiac Artery Bypass Graft (CABG) surgery 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.

Medicare Spending Per Beneficiary

Having information on health care spending is critical to consumers, purchasers, and other stakeholders in both the public and private sectors. We have long supported the addition of spending, cost, and resource use measures in the IQR – within the context of quality – for the purposes of understanding the value of care provided within local communities and variation across regions. Thus we commend CMS for proposing a "spending per beneficiary" measure for FY 2014. **We support CMS using this measure in the FY 2014 program, but suggest modifications to improve its usefulness.**

As described in the proposed rule, the measure would cover a period beginning three days before the index hospitalization to 90 days following the discharge. We suggest that clarification be made to ensure that the pre-index hospitalization timeframe will only include costs directly related to preparations for scheduled surgical procedures. We also strongly urge CMS to shorten the post-discharge period to 30

days, which would make it consistent with other post-hospitalization measures that are focused on improving care across settings.

Our main concern with the proposed 90-day post-discharge time frame is that the farther away from the index hospitalization, the less responsibility and influence on care a hospital can reasonably be expected to have. Within a 90 day window there will be hospitalizations that have nothing to do with the index admissions, could potentially dominate the spending during the period, and yet not be appropriately attributable to the index hospitalization. The proposed rule states that this time period was constructed to emphasize the importance of care coordination. While we share the interest in improving coordination, and believe hospitals should be held accountable, we are concerned that the 90-day time frame is excessive. **We believe the goal of this measure is to identify which hospitals are offering the greatest value, based on their cost as viewed within the context of their overall performance.** Assessing care coordination could be accomplished, for example, by creating a series of patient-reported measures that expand upon those already in HCAHPS. Patient experience could be paired with other assessments of transitions to determine that appropriate coordination occurred between and among post-acute providers, including those in the community. We also recommend that in order to capture the spending experienced over the 90 day post-discharge period, CMS provide leadership in the development of a spending measure that would be appropriate for an ACO model.

We do support the way in which this measure addresses geographic variation, by adjusting for the input price only, as well as the way in which the measure deals with DSH payments and IME payments. More information is needed, however, on how the measure would combine the HCC score with the MS-DRG score for the index admission.

Finally, we ask CMS to provide more detail on how this measure will handle "outlier patients" for whom spending is extremely high. We suggest that CMS explore the use of "trim points" to limit the impact of these potential cases on a hospital's overall score. We also suggest that CMS explore calculating the mean spending, rather than using the median, again due to the potential effect of very high cost patients.

FY 2015 Measures

As with the addition of HAI measures in FY 2014, we strongly support the addition of measures of MRSA and clostridium difficile (c-diff) in FY 2015. **We urge CMS to retain these measures in the final rule, given their enormous importance to making hospital care safer for all patients.** We also encourage CMS to seek NQF endorsement of these two Centers for Disease Control and Prevention-developed measures.

We also support CMS's proposal to implement two sets of chart abstracted measures in FY 2015, one related to stroke care and the other related to venous thromboembolism. Stroke is a high volume, high cost condition, and an area where evidence-based practice can lead to significant improvements in patient care. VTE is largely preventable, and when it does occur, it adds significantly to the cost of patient care. The measures in both sets, while chart abstracted, are also electronically specified and are among the measures included in stage I of the Meaningful Use of Health Information Technology program, thereby permitting alignment with the IQR. We also support the addition of the measure of healthcare personnel influenza vaccination.

Finally, as noted earlier in our comments, the measures proposed for FY 2015 are extremely important to consumers and purchasers, and in the case of the stroke measures, are already being collected by hospitals across the country.[2] We urge CMS to consider moving these measures into the IQR in FY 2014, with data collection beginning in 2012.

[2] The stoke set in particular is already being collected by 1400 hospitals and submitted to the American Heart Association.

Future Measure Topics

We are very pleased to see important measure topics such as the safe surgery checklist, care transitions, mortality, additional HAIs, and medication safety being considered by CMS for inclusion in the IQR in future years. We appreciate the comprehensive list of measure topics and concepts provided in the proposed rule, and believe that **in many cases, they represent the progression from the early portfolio of IQR measures that are 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.** We ask CMS to prioritize, by focusing on those topics for which there are already specified measures available, and divide this list into a set of recommendations for measure implementation and another for measure development.

In terms of measure implementation, **we recommend rapid inclusion in the IQR of the following measures** which a) reflect high volume conditions and/or procedures; b) further the goals of the triple aim; and c) 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 five readmissions, and two mortality, measures listed in the proposed rule.
- The registry-based CABG composite score (referred to above in the section on FY 2014 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 *Care Transition Measure* and *Potentially Avoidable Complications,* we urge CMS to put these in the inpatient quality reporting pipeline and the Hospital Compare reporting process as rapidly as possible to allow for rapid implementation into the hospital value-based purchasing program. We also offer suggestions 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:

- *The Care Transition Measure (CTM-3):* While the "future measures and topics" matrix lists care coordination as an important area for the IQR, we do not support the use of the cardiac rehabilitation referral measure, which can easily fall into the "check-the-box" measure category. Instead, we urge CMS to consider the NQF-endorsed 3-Question Care Transition Measure, which asks the following:
  - *The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital*
  - *When I left the hospital, I had good understanding of the things I was responsible for in managing my health*
  - *When I left the hospital, I clearly understood the purpose for taking each of my medications.*

  This measure could fulfill the role described above in our comments on the "Medicare Spending per Beneficiary" measure of the need for a measure of care transitions from the patient's perspective, using patient-reported data.

- *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 of such a measure that we would hope to see endorsed by a multi-stakeholder consensus-based process and ultimately widely implemented 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 leveraging 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. For the IQR and VBP programs to evolve and mature, 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.

QIO Regulation Changes for Serious Reportable Events

We support CMS' proposal to require hospitals to submit to their QIO, within 21 days, a copy of the medical record for any patient for whom a serious reportable event occurred during the course of treatment in the inpatient setting. We agree with CMS that this will provide the information needed to assess quality and safety of care at the hospital level, and that it will further the goals of the triple aim: better health, better care, and lower cost through quality improvement.

Alignment Across HHS Programs

The Meaningful Use program – when considering which clinical measures will be included – will give priority to those measures already in use in the IQR. This benefits both programs, since having a measure in the IQR reflects a certain level of consensus that has formed around the measure, and having

the measure in the Meaningful Use program means that hospitals will be collecting this measure ultimately through an EHR, thereby improving efficiency of data collection. This makes it all the more important that CMS implement meaningful outcomes, safety, and cost-oriented measures, so that the pool of measures that are available not only for the Meaningful Use program, but also for the Hospital Value-Based Purchasing program, are ones that will help advance the goals of the aforementioned three part aim.

Regarding CMS' request for comments on the approach for moving away from chart-abstracted data to measures that are electronically specified, we do agree that selecting a specific calendar year for the end date is an appropriate strategy. We suggest that in conjunction with setting this date, CMS develop a glide path for hospitals and data collection vendors to ensure that the proposed transition timeframe is feasible.

Hospital Value-Based Purchasing

We strongly support CMS' proposal to simultaneously specify additional measures for the IQR and the Hospital VBP program. We believe that merging the rulemaking for these programs, as it pertains to proposed quality metrics, will be a reflection of efficiency building within the agency, and will streamline efforts by stakeholders to analyze proposed rulemaking activity.

Readmissions Reduction Program

We support CMS' proposal to adopt, without alteration, the three NQF-endorsed 30-day readmission measures related to heart failure, pneumonia, and acute myocardial infarction (AMI), for the initial year of this program. Consumers and purchasers viewed these measures favorably when they were in the endorsement pipeline at NQF, as well as when they were being proposed for implementation in the IQR, and we believe they will be appropriate for use in the readmissions reduction program. These measures have been designed to identify only those readmissions that were preventable, and will not negatively affect hospitals whose patients are readmitted for scheduled procedures post-index hospitalization.

Regarding the public reporting of hospital-specific readmission rates, we ask CMS for clarification on how the data from this program will be reported in light of the three readmission rate measures that are already displayed on *Hospital Compare.* Currently, readmissions are displayed as either "same as the national average," "worse than the national average," or "better than the national average," with very little range in the distribution to allow consumers and purchasers to attain a meaningful sense of how well hospitals in their local community are performing. We urge CMS to take this opportunity to 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.

Finally, we strongly support CMS collecting readmission rates for all patients, using all-payer data, as specified in Section 1886(q)(8)(A) of the Affordable Care Act.

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the IQR program. 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
Alliance for Quality Health Care
American Federation of State, County & Municipal Employees (AFSCME)
American Hospice Foundation
Buyers Health Care Action Group

Center for Medical Consumers
Childbirth Connection
Dallas-Fort Worth Business Group on Health
Employers Health Coalition of Ohio, Inc.
Employers' Coalition on Health
Florida Health Care Coalition
Health Action Council Ohio
Health Policy Corporation of Iowa
Healthcare 21 Business Coalition
Iowa Health Buyers Alliance
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