



June 30, 2014

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

RE: CMS-1607-P: Proposed Changes to FY 2015 Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; and Quality Reporting Requirements for Specific Providers.

Dear Ms. Tavenner:

The 26 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 2015 Medicare Inpatient Prospective Payment System (IPPS) rule. The detailed comments that follow this letter pertain to the following sections of the Notice of Proposed Rule Making (NPRM):

- Non-Payment for Preventable Hospital-Acquired Conditions (HACs), Including Infections, from the Deficit Reduction Act of 2005
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital-Acquired Conditions Reduction Program
- Hospital Inpatient Quality Reporting Program
- Electronic Health Record Incentive Program
- Long-Term Care Hospital Quality Reporting Program
- PPS-Exempt Cancer Hospital Quality Reporting Program
- Requirement for Transparency of Hospital Charges Under the Affordable Care Act

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

- Increasingly defining better, safer and more affordable care based on improved patient outcomes;
- Advancing electronic reporting systems to drive performance improvement; and
- Increasing accountability for improved maternity care.

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Despite continued positive momentum, significant measure gaps remain in areas critical to consumers and purchasers - the ultimate "customers" or end-users in healthcare. We urge CMS to devote resources to measure development that can fill the most critical gaps, particularly in areas of care where patient-reported data provide insight on experience of care, outcomes and functional status. Towards that end, we are hopeful that CMS, the Office of the National Coordinator for Health Information Technology (ONC) and other federal partners will leverage the Patient Reported Outcomes Measurement Information System (PROMIS) to create patient-reported outcome measures that support patient, family and caregiver engagement. Furthermore, we hope that those devoting resources to building capacity for the collection of patient-generated data will use examples of success (e.g., Dartmouth, Geisinger, California Joint Replacement Registry, U.K.'s National Health Service, and Sweden's Rheumatoid Arthritis Registry), to support swift adoption of best practices, such as:

- Fitting patient-reported measures into the flow of care
- Educating consumers, clinicians and support staff on the advantages of collecting patient-reported data
- Merging patient-reported measurement with data from other sources (e.g., claims, medical records, registries, etc.)
- Continuously improving patient-reported measurement systems based on users' experiences and new technologyⁱ

In the meantime, we also hope that CMS will take a timely approach to implementing existing measures that address gap areas in the short-term, prioritizing those recommended within the Measure Applications Partnership's (MAP) "families of measures." We believe this work offers important guidance to CMS about which measures should be prioritized for inclusion on the list of Measures Under Consideration and immediately adopted for use across multiple programs in both the public and private sectors.

We provide additional comments below on opportunities to accelerate the aforementioned aspects of this proposed rule. Additionally, the enclosed Addendum includes detailed comments on each of the individual programs noted above.

Focusing on patient outcomes must remain a key priority across all programs

We encourage CMS to pursue value-based efforts that eliminate unproductive, competing priorities by achieving alignment with state and private-sector partners. Within these efforts and across HHS initiatives, we urge CMS to promote the consistent prioritization of high value measures, including outcomes, to facilitate rapid improvements in care and judicious use of public funds. To that end, we are concerned with the proposed inclusion of low value and "topped out" process measures in the Electronic Health Record (EHR) Incentive and the Inpatient Quality Reporting (IQR) Programs. This approach inhibits progress and we urge CMS to set a higher bar for meaningful measures that drive improvement.

Advancing electronic reporting systems should support meaningful measurement

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

approach that prioritizes measures of patient outcomes with demonstrated opportunity for improvement.

In addition, we encourage CMS to align efforts with other agencies and with all stakeholders, including the vendor community and leaders in EHR adoption and person-centered care (e.g., practices receiving Patient-Centered Medical Home Certification), to implement concrete mechanisms that support the reporting of electronic quality measures of outcomes and patient-reported health status by FY2017. Specifically, requiring public reporting of robust electronic measures (e.g. e-measures), such as the 30-day risk standardized AMI mortality e-measure, and components of the National Institutes of Health's PROMIS tool, should receive high priority. Simultaneously, advancement of both quality measurement and electronic reporting should include mechanisms for real-time, and bi-directional feedback from the patient, allowing patients to access and view data from their providers' electronic health records via patient portals, as well as contribute patient-generated health data that informs clinical decisions and could serve as the foundation for future measure development.

Increasing accountability for improved maternity care needs to happen in the short-term

Maternity care plays a major role in the U.S. healthcare system, as 21% of patients discharged from U.S. hospitals in 2011 were childbearing women and newborns.ⁱⁱ Currently, private insurers (covering 51% of all births) and Medicaid programs (covering 42%) are getting poor value for their considerable investment in maternity care. This translates to wasted resources for taxpayers, employers and families.ⁱⁱⁱ We recognize maternity is not as relevant to Medicare but greatly appreciate its inclusion in IPPS programs and improving care for all patients, regardless of insurance status.

To help drive improvement in maternity care, we appreciate the inclusion of the Elective Delivery Prior to 39 weeks (NQF #0469) measure in the Hospital Value-Based Purchasing Program in FY 2017, as well as the maternity measures proposed for voluntary electronic reporting in the IQR Program. Nevertheless, we are concerned by the lack of clarity in the proposed approach to voluntary electronic reporting and urge CMS to clarify this terminology. We provide additional comments on specific measures proposed for voluntary electronic reporting below, and elaborate on our concern that CMS did not adopt the 2014 MAP pre-rulemaking recommendation for inclusion of the PC-02 Cesarean Section measure (NQF #0471).

Results from the *Listening to Mothers III* survey provide rationale to encourage the swift implementation and required reporting of these measures no later than FY 2017 – recognizing that 40 percent of childbearing women from a national sample indicated that online hospital quality information had been a major factor in their choice of a hospital for giving birth.

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

Sincerely,

American Benefits Council
American Cancer Society Cancer Action Network
American Federation of Teachers
American Hospice Foundation
Business Healthcare Group
Center for Healthcare Decisions
Citizen Advocacy Center
Consumers' CHECKBOOK/Center for the Study of Services
Consumers Union
Equity Healthcare
Group Insurance Commission, Commonwealth of Massachusetts
Health Policy Corporation of Iowa
Iowa Health Buyers Alliance
Lehigh Valley Business Coalition on Healthcare
Maine Health Management Coalition
Mothers Against Medical Error
National Coalition for Cancer Survivorship
National Partnership for Women & Families
Pacific Business Group on Health
Partnership for Patient Safety
Project Patient Care
St. Louis Area Business Health Coalition
The Alliance
The Empowered Patient Coalition
UNITE HERE Health
Wyoming Business Coalition on Health

ADDENDUM: DETAILED COMMENTS ON IPPS NOTICE OF PROPOSED RULEMAKING, FY 2015

Non-Payment for 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 conditions that patients acquire during a hospitalization, or in other words, were not “present on arrival” to the hospital. No plans have been specified for expanding the program, although CMS has requested additional measure topics for future inclusion.

We are frustrated by CMS’ lack of responsiveness to ongoing requests to publically report the important patient safety information included in this program in the short-term. We recognize that CMS is taking important steps to remedy gaps in public reported patient safety measures through the Hospital-Acquired Conditions Reduction Program, but in the meantime, the current state of transparency around important patient safety data is greatly lacking. We fear there has been a measureable setback in the hard work that has been done by CMS, consumers, purchasers and other stakeholders to promote better transparency over the last several years due to the removal of publically- reported information on hospital-acquired conditions included in Leapfrog’s Hospital Safety Score. This will remove another resource that offers consumers meaningful information to help guide their care decisions.

We urge CMS and the Centers for Medicare to reconsider making the HAC rates from this program publically available and easily accessible (e.g., Hospital Compare, data.medicare.gov). We suggest at the very least sharing the raw counts of hospital-acquired conditions for which better measures have not yet been implemented and no better source of information exists.

In response to CMS’ request for additional measure topics for this program, we recommend measures of surgical site infections following high-volume procedures, such as cesarean section surgery, hip replacement and knee replacement surgery.

Hospital Readmissions Reduction Program (HRRP)

C-P Alliance continues to support this program and believes it serves as an important policy lever that drives improvement in patient care. Moreover, we believe this program supports innovation that addresses patient outcomes, far beyond readmissions, by encouraging increased shared accountability, communication, and coordination across providers and the full continuum of patient care. We are pleased by the progress already achieved-- contributing to 150,000 fewer avoidable readmissions overall among Medicare beneficiaries between January 2012 and December 2013, a reduction of approximately 8%.^{iv} We also recognize reductions in avoidable readmissions for AMI, heart failure and pneumonia patients between 2009 and 2012; a result that is closely tied to the implementation of this program.^v

In light of these successes, we urge CMS to maintain a consistent and timely approach to expanding this program. We were disappointed that no new measures have been proposed for FY 2016; thus, losing the momentum from recent successes. We encourage CMS to continue to strengthen this program through the inclusion of new measures for FY 2016 and FY 2017, as described in more detail below.

New Measures for FY 2017

C-P Alliance believes that the more conditions and procedures captured in this program, the greater its capacity to reduce avoidable readmissions for *all* patients. We therefore support the proposed expansion of this program to include the Hospital 30-day, All-cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery measure. However, we urge CMS to include this measure by FY 2016, rather than FY 2017, as proposed. This measure was conditionally supported by MAP pending NQF-endorsement, and the endorsement process will be complete in this calendar year. In addition to inclusion of the proposed CABG measure, we urge CMS to consider the addition of the following two measures no later than FY 2017:

Readmission measure for Percutaneous Coronary Intervention (PCI) - NQF #0695

MedPAC recommends incorporating a readmission measure for PCI into this program. Data from the American College of Cardiology's CathPCI Registry has demonstrated that 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. We hope CMS will examine pairing this measure with the Hospital 30-day, All-cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery measure.

Hospital-Wide All-Cause Readmission Measure - NQF #1789

We recommend this measure for inclusion to promote system-wide progress in reducing avoidable readmissions and to encourage continued alignment with the IQR Program. While the condition-specific readmission measures offer valuable and actionable information for quality improvement efforts, this measure offers equally important information about system-wide performance and this program's overall impact.

Overall Program Implications

We recognize that many stakeholders have concerns about the potential unintended consequences of this program, particularly for hospitals serving patient populations with complex social situations. We acknowledge that providers cannot control all aspects of patient outcomes and that patient choices, life circumstances, sociodemographic factors, and the availability of community resources can all contribute to outcomes. However, providers are increasingly learning how to "meet their patients where they are," recognizing the role of non-medical factors, and adapting care practices to address patients' needs and circumstances. Many safety net providers are achieving significant improvements in reducing avoidable readmissions among patients facing very challenging life circumstances outside of the healthcare system. For example, America's Essential Hospitals has been a champion for hospitals and health systems adapting their practices to the needs of vulnerable populations. Through their participation in the public-private Partnership for Patients initiative, America's Essential Hospitals prevented 1,184 harmful events and saved \$12 million through reductions in hospital-acquired conditions and avoidable readmissions.^{vi} Their success demonstrates not only that safety net hospitals are capable of demonstrating innovative approaches to reducing avoidable readmissions, but that they are in fact uniquely positioned to do so due to their experience in treating diverse and complex patient populations.

We ask CMS to respond to concerns from providers, particularly those serving disadvantaged populations, by exploring alternative payment mechanisms that take into account the complexities in caring for extremely disadvantaged patients. In particular, we urge CMS to consider ways to support providers serving high proportions of low-SES patients, who are either high-performers or are exhibiting demonstrable improvement. We also believe that CMS should facilitate the sharing of best practices and expand the public's ability to access meaningful information on readmissions, such as stratification by race, ethnicity, language, gender and disability.

The Consumer-Purchaser Alliance supports the current measures included or recommended for future inclusion in this program. We acknowledge current discussion about adjusting these measures for SES factors but believe these deliberations are still underway, and that current measure science supports these measures as indicators of improvement opportunities. Evidence confirming assumptions that this program is unfairly penalizing certain providers is insufficient to warrant immediate changes to this program that could create a double standard for our nation's citizens who are in need of culturally competent, accessible care. Nevertheless, we support efforts to understand the potential impact of this program for improvement, as well as potential unintended consequences that could affect access to care for vulnerable populations.

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

Last year we were pleased to see the inclusion of PSI-90: Composite Measure of Patient Safety for Select Indicators (NQF #0531) and the Centers for Disease Control and Prevention's measure for Central-Line Associated Bloodstream Infections (NQF #0139) in this program. We continue to support the inclusion of these measures for FY 2015, as they represent important patient safety outcomes for consumers and purchasers. We understand that the PSI-90 measure may undergo substantial changes as part of the NQF endorsement maintenance process, particularly with the potential addition of PSI-9: Perioperative hemorrhage rate, PSI-10: Perioperative physiologic metabolic derangement rate and PSI-11: Post-operative respiratory failure rate. We are supportive of changes to the measure that include these additional indicators, as we believe they are also important outcomes that will ultimately strengthen the measure's value as a comprehensive patient safety composite. In their implementation of this measure, we urge CMS to support public reporting of both the full composite score, with the ability to drill down to individual measure scores.

New Measures for FY 2016 and beyond

We appreciate CMS' intention to include the Methicillin-Resistant Staphylococcus Aureus (MRSA) (NQF #1717) and Clostridium Difficile (NQF# 1717) measures in this program in FY 2017, as they address an important gap in addressing high-volume infections. Similarly, we are encouraged by the addition of the Elective Delivery Prior to 39 weeks (NQF #0469) measure that promotes the importance of high-value maternity care, but encourage the adoption of all three of these measures by FY 2016. We note that per the requirements of this program, we believe all of these measures will have been included in the IQR Program and posted on *Hospital Compare* for a full year by this time. We also support the adoption of the proposed Complication Rate Following Elective Primary Total Hip and Knee Arthroplasty measure

(NQF #1550) and encourage CMS to consider its implementation by FY 2018, a year prior to what has been proposed. We believe that since hip and knee replacements are often non-emergent, high-volume, and high cost procedures, information on outcomes is especially important for providing consumers the opportunity to research the quality of care provided in their local hospitals. The addition of these measures would create a strong suite of hip and knee replacement-related measures, complimenting those in the IQR Program, the Readmissions Reduction Program, and the HAC measures that we have recommended for the HAC non-payment program.

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

- PSI-4: Death among surgical inpatients with serious treatable complications (NQF #0351)
- COPD 30-day mortality (NQF #1893)
- AMI Payment Per Episode

In response to CMS' request for input on proposed condition-specific episode-based standardized payment measures, we applaud the continued consideration of opportunities to align measures across federal programs. We support this direction, but urge CMS to consider additional focus on high-impact conditions, such as heart failure, stroke and diabetes. Moreover, high-impact conditions should be monitored alongside data tracking volume of procedures in an effort to simultaneously identify geographic areas and providers where volume may be unduly high and potential issues related to appropriateness and overuse need to be addressed.

Measures Proposed for Removal

We strongly support the proposed removal of the six topped-out process measures (e.g., NQF #0417: Initial Antibiotic Selection) for which most hospitals are performing in the 95-99% range.

Other Proposed Changes to the HVBP for FY 2017

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

- 20% Safety (previously 15 %)
- 30 % Clinical Care (previously 35%)
 - 5% clinical care – processes (previously 10%)
 - 25 % clinical care – outcomes (no change proposed)
- 25% Efficiency (no change proposed)
- 25% Patient- and Caregiver-Centered (PCC) Experience of Care/Care Coordination (no change proposed)

Targeted attention for both clinical outcomes and patient safety will undoubtedly support attainment of the National Quality Strategy goals. However, in order for this program to realize its full potential, we encourage swift adoption of additional measures within the Efficiency and Patient- and Caregiver-Centered Experience of Care/Care Coordination domains. We hope that CMS will add measures identified by MAP's "families" for affordability and person-centered care, respectively, to help strengthen these domains.

Hospital-Acquired Condition Reduction Program

We support CMS' implementation of the Hospital-Acquired Conditions (HACs) Reduction Program to increase transparency and accountability for key patient safety issues, and we applaud the program's success to date in the prevention of nearly 15,000 deaths, avoidance of 560,000 patient injuries, and savings of approximately \$4 billion^{vii}. However, we offer an amendment to the provider-centric terminology suggested by this program and ask CMS to consider the term "hospital-acquired complications," rather conditions. We feel this change would signal more clearly to consumers and purchasers about the intent of this program, which focuses on complications that arise from inappropriate delivery of care, as opposed to an illness or disease that a patient may have before entering the health care system.

New Measures for FY 2016 and beyond

We are concerned that CMS has not proposed any additional measures for inclusion in this program in the near-term. In particular, we recommend the inclusion of the MAP recommended measure PSI-16: Transfusion Reaction (NQF # 0349) no later than FY 2016. This NQF-endorsed outcome measure assesses illness or injury resulting from administration of mismatched blood or blood products. These events are considered to be almost entirely preventable and have been classified as such by the 2011 Update to the *NQF Serious Reportable Events in Healthcare Report*^{viii} and the Joint Commission.^{ix} Ultimately, this rare event could be appropriately included in a measure of all-cause harm, which we fully support.

We believe the expansion of this program to include an all-cause harm measure would increase its capacity to reduce patient harm. Moreover, its inclusion would promote a more accurate definition of safety as it is understood by consumers and purchasers. We hope CMS will develop this measure as quickly as possible. Additionally, we encourage CMS to address persisting gaps in this program relevant to adverse drug events, ventilator-associated events (VAEs), diagnostic errors, and a broader scope of surgical site infection measures. With regard to measures of medication safety in particular, we point to an existing measure from Brigham and Women's Hospital, Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (NQF # 2456). This outcome measure assesses errors in admission and discharge medication orders due to problems with the medication reconciliation process.

Other Proposed Changes to the HAC Reduction Program for FY 2016

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

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

We do not support CMS' proposal to change the weighting of the existing domains, as we feel that this approach promotes an overly narrow definition of HACs that places too much emphasis on infections alone. While infections are certainly very important patient outcomes, patients are also exposed to risks from many of the outcomes in PSI-90, such as pressure ulcers, postoperative hemorrhage, sepsis or

accidental puncture/laceration. CMS should take a more balanced approach to weighting the existing domains in order to place a high bar for hospitals to avoid both infections and harmful complications that can be prevented.

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

Lastly, CMS has also proposed a two year data collection period for the CDC measures for CAUTI and CLABSI. We strongly disagree with this approach and hope that CMS will reconsider quarterly collection and calculation of these measures for Domain 2 of this program. Quarterly data would be more actionable for providers in addressing areas in which they would like to improve, and would also allow consumers and purchasers to have timely information regarding areas of care that are meaningful and important to them.

Hospital Inpatient Quality Reporting Program (IQR)

We appreciate the direction CMS has taken with this program since FY 2005, transforming it from a set of discrete process measures oriented toward internal quality improvement, into a comprehensive program that supports the transparency of meaningful measures that strive to meet the needs of multiple stakeholders. We are pleased with the strong outcome measures addressing a broad scope of high-impact conditions proposed for implementation in FY2017. Moreover, we are pleased with the degree of alignment with existing programs (e.g., EHR Incentive Program, Hospital Readmissions Reduction Program).

New Measures for FY 2017

We commend CMS for the proposed inclusion of 7 measures in the IQR Program for FY 2017 that seek to address high-value care and improved patient outcomes relevant to Coronary Artery Bypass Graft (CABG) surgery, episode-of-care payments, patient safety, and maternity care.

CABG Surgery Measures

There is strong evidence pointing to the high cost of CABG surgeries, as well as demonstrated variation in performance, signaling a key opportunity for improvement. For reasons stated earlier we support the inclusion of these two harmonized measures. We also believe the current versions of these measures appropriately risk-adjust for differences across hospitals based on patient clinical factors alone. C-P Alliance has reviewed these measures throughout NQF's endorsement process and believes the measure developers have offered strong data demonstrating that risk-adjusting for sociodemographic variables does not affect hospital performance. Moreover, we believe the current versions of these measures appropriately illuminate quality differences and hold all hospitals to an achievable standard of high-quality care.

Episode-of-Care Payment Measures

We are pleased to see the addition of these payment measures, which can be reported with measures of quality to help illustrate the value of health care to consumers and purchasers. We recommend that

CMS monitor the results of these measures with respect to volume of procedures in an effort to identify potential issues related to appropriateness of services.

Safety Measures

We support the inclusion of the Sepsis Measure, which aligns with existing initiatives focused on improving this important patient safety outcome. However, we urge CMS to place additional resources into the development of a strong sepsis outcome measure, recognizing that blood infections have been found to play a role in up to half of patient deaths in U.S. hospitals^x. We were disappointed to see that CMS did not recognize the recommendation from the MAP to also include NQF #0363: PSI 5 Foreign Body Left During Procedure. This measure represents the opportunity to swiftly fill an important gap in publically available patient safety information and we urge CMS to reconsider its inclusion. Ultimately, we hope CMS will devote resources to an all-cause harm measure, as proposed for the HAC Reduction Program.

Maternity Measures

C-P Alliance strongly encourages CMS to include the Healthy Term Newborn, Exclusive Breast Milk Feeding, *and* PC-02: Cesarean Section as mandatory measures no later than FY 2017. Further, we believe that exclusive electronic reporting of these measures could ultimately reduce the burden of collection and increase the potential for timely feedback to all stakeholders on the ever important area of maternity care.

The benefits of breastfeeding for both mothers and babies are well established and accrue over a lifetime for both.^{xi} The proposed measure also has the virtue of being included in The Joint Commission's core Perinatal Care measure set (PC-05), which hospitals with more than 1,100 births annually are now required to collect and report. Use of standardized measures helps avoid confusion among consumers and health professionals and reduces duplication of related measure concepts and burden of collection.

With regards to the Healthy Term Newborn measure, we thank CMS for their consideration of this important outcome measure that aligns with reporting requirements for the EHR Incentive Program. We note that this composite measure has recently been refined and hope that CMS will swiftly adopt the updated version, entitled Unexpected Newborn Complications, which is already being used in all California and Washington State hospitals and in all National Perinatal Information Center hospitals across the country. Moreover, this measure typically applies to more than 80 percent of hospital births and offers an opportunity to demonstrate that overzealous improvement in some aspects of care (e.g., cesarean reduction) is not compromising newborn well-being.

Finally, hospitals with over 1,100 births per year are now mandated to collect and report the Cesarean measure, which is available electronically. We understand that CMS has proposed inclusion of this measure "in the future," but we are hopeful they will consider implementation without delay. To support this recommendation, we point to opportunities for alignment, such as The Joint Commission, as well as CHIPRA Children's Health Care Quality measure set. We also note that the two leading obstetric professional societies, American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine, recently released a detailed set of consensus recommendations for safely reducing the rate of initial or primary cesareans, stating that this procedure is overused and that there are many safe ways to bring the rate down.^{xii}

In addition, we support the Hearing Screening Prior to Hospital Discharge (NQF #1354) measure in light of its widespread use and support from the MAP, but request that CMS provide additional information regarding their rationale for inclusion of the CAC-3 Home Management Plan of Care Document Given to Patient/Caregiver. This measure's loss of endorsement from NQF is cause for concern, but more importantly, we do not feel this documentation measure appropriately contributes to evaluating the state of perinatal care in the U.S.

Re-adoption of topped-out process measures

We disagree with CMS about the potential value of monitoring measures for which all hospitals are already achieving high levels of performance. Therefore, we do not support the readoption of the suite of 12 topped-out chart abstracted measures that have been proposed for voluntary electronic reporting in the IQR Program, including:

1. AMI-8a: Primary PCI received within 90 minutes of hospital arrival (NQF #0163)
2. PN-6: Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (NQF #0147)
3. SCIP-Inf-1: Prophylactic antibiotic received within one hour prior to surgical incision (NQF #0527)
4. SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients (NQF #0528)
5. SCIP-Inf-9: Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero (NQF #0453)
6. STK-2: Discharged on antithrombotic therapy (NQF #0435)
7. STK-3: Anticoagulation therapy for atrial fibrillation/flutter (NQF #0436)
8. STK-5: Antithrombotic therapy by the end of hospital day two (NQF #0438)
9. STK-10: Assessed for rehabilitation (NQF #0441)
10. VTE-4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol
11. AMI-2 Aspirin Prescribed at Discharge for AMI (NQF #0142)
12. AMI-10 Statin Prescribed at Discharge (NQF #0639)

We are hopeful that increased focus on the refinement and development of outcome measures will support the alignment between these two programs for Stage 3 of the Meaningful Use program. In the meantime, the proposed inclusion of measures that have no demonstrated impact on quality improvement sends the wrong message about the goals of both programs and inappropriately distracts resources from areas that would more readily benefit from targeted attention. We recognize that the measures for Stage 2 are already finalized and represent an important step in the evolution of electronic reporting systems. However, we hope CMS will address further alignment with IQR through the advancement of electronic quality measures required for the EHR Incentive Program, rather than allowing the IQR Program to take a step backwards. In the meantime, should CMS choose to move forward with readopting topped-out measures for the IQR Program, we hope they consider reporting these measures somewhere other than *Hospital Compare* to avoid crowding the space of measures that are more meaningful to consumers and purchasers.

Measures Proposed for Removal

We strongly support the proposal to remove 10 topped-out measures (e.g., NQF #0132: AMI-1 Aspirin at arrival), which offer no useful information about the quality of care provided or its outcomes, and create unnecessary administrative burden for providers.

Future IQR Measures and Topics

We commend CMS for their intention to propose the Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge measure (NQF #0475) in future years.

We also request that CMS devote attention to:

- High volume conditions and/or procedures;
- The goals of the three-part aim; and
- Alignment between the IQR and other HHS programs.

Safety/Care Coordination Measures

In addition to the proposed measures for inclusion in the IQR Program for FY 2017, we encourage CMS to prioritize measures that fill important gaps in patient safety, including:

- Three NQF-endorsed measures that look at the proportion of patients hospitalized with 1) AMI; 2) stroke; or 3) pneumonia, and who experienced a potentially avoidable complication either during the hospital stay, or in the 30-day Post-Discharge Period (NQF#0704, 0705 and 0708)
- Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (NQF #2456), which assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process.

Maternity Measures

CMS should focus on the development of a multi-dimensional patient-reported composite measure of maternity care in the near-term, which could be collected six weeks after birth to measure outcomes and identify common new-onset morbidities during a post-partum visit. Additionally, we recommend the adaption of the generic Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure the experience of care of childbearing women and newborns. We also support the development of measures that evaluate unexpected maternal complications, such as post-cesarean section infection, complications among low-risk women, and vaginal birth after cesarean in low-risk women, which could build off of AHRQ's IQI #22. Lastly, we believe that the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)'s provider-level measures, specifically applicable to the group with the most hands-on contact with mothers and babies around the time of birth, include several excellent candidates for CMS' future consideration of additional maternity measures (e.g., 03 Skin-to-Skin is Initiated Immediately Following Birth and 04 Duration of Uninterrupted Skin-to-Skin Contact).^{xiii}

Patient-Reported Outcome Measures

As previously noted, we urge CMS to identify additional measures that use patient-reported data to assess experience of care, outcomes, including functional status; particularly for high-impact and cross-cutting areas of care, such as the treatment of cancer, pediatric care and behavioral health. Increasingly, bi-directional Health Information Technology platforms and patient-engagement focused initiatives are seeking to contribute to this effort (e.g., Doctella.com; *Patients Like Me*). We look forward to working with CMS to advance this priority.

Electronic Health Record Incentive Program

[See comments within IQR section.](#)

Long-Term Care Hospital Quality Reporting Program (LTCHQR)

We commend CMS for the inclusion of outcome measures that address high-impact patient safety concerns, such as infections and readmissions, as well as the inclusion of measures of patient experience and functional outcomes. We urge CMS to adopt outcome measures more quickly. In particular, the adoption of the MRSA, c-diff, and a 30-day readmission rate measures finalized for FY 2017 in last year's rule should occur no later than FY 2016.

We further support the addition of the three new quality measures proposed for FY 2018, including:

- Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
- Functional Outcome Measure: Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support
- Ventilator Associated Event

Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

We appreciate the attention this measure provides to improving care for patients with functional limitations, particularly given the high prevalence of this issue for LTCH patients. We also value the importance of care planning in encouraging patients to work in partnership with their providers to improve their outcome. Nevertheless, in order to encourage collaboration between patient and provider, and meaningful goal-setting and shared decision-making, we urge CMS to develop this measure and the CARE tool in a way that promotes assessment of actual change in patients' functional status over time or attainment of collaboratively set goals. Specifically, this measure should require the reporting of the functional assessment scores *and* the delta between those scores. Ultimately, we encourage resource investment for further development of measures that reflect the patient-reported perspective on functional improvement and care planning, as we believe the patient is the ultimate source of information in evaluating improvement in this area of care.

Functional Outcome Measure: Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support

Similar to the previously described measure, we support the direction of this measure and its attention to the strong body of evidence that already exists relevant to improving patients' functional status in LTCH settings. We also believe that functional improvement is particularly relevant for patients who require ventilator support because these patients are likely to have comorbidities that affect their mobility. We are encouraged the CMS has taken a more outcomes-focused approach to this measure and required the reporting of a change in mobility score between admission and discharge. As stated previously, we hope that future efforts will focus on opportunities to integrate the patient's voice into functional assessment. Additional attention should also be given to measures related to pain and delirium, which are key impediments to mobility not only for patients requiring ventilator support, but more broadly, the LTCH population.

Ventilator-Associated Event

We support this outcome measure and concur with the rationale CMS has provided regarding the importance of ventilator-associated events as a high-priority complication in the LTCH settings.

Furthermore, we appreciate CMS' consideration for the utility of this measure given that it can be used across multiple settings.

We are encouraged by the proposed future topics for consideration in filling important gaps in this program, and urge CMS to take a swift approach to prioritizing gaps in patient experience of care (e.g., HCAHPS), care transitions, care planning and pain management. We do, however, believe that measures relevant to behavioral and mental health are missing from this list of future priorities and hope that CMS will include them in the final rule. Existing measures from the hospital and nursing home settings should act as a resource in identifying opportunities to address measure gaps in the short-term.

Finally, we recognize that CMS is taking preliminary steps to encourage transparency in this area of care, but urge the implementation of a timeline that is similar to other programs (e.g., public reporting after measures have been in program for a year).

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.

The majority of measures adopted for this program include clinical process measures, including the newly proposed measure for inclusion in FY 2017, External Beam Radiotherapy for Bone Metastases (NQF #1822). While we understand the relevance of a few of these measures, including NQF #1822, for filling gaps in important areas of care where no better measures exist, we are concerned that not enough progress is being made to elevate this program to truly reflect patient, family, and caregiver outcomes and experience of care (e.g. pain relief, palliative care, quality of life). In spite of a large evidence base, measurement of cancer outcomes lags behind other high-prevalence conditions for the Medicare population. The opportunity is great and patients badly need this information in choosing where they will go for treatment. In particular, we urge CMS to include the HCAHPS survey in this program immediately to ensure that the experiences of patients across all institutions are assessed and considered. We are disappointed that this proposal does not reflect MAP's support for the near-term inclusion of PSI 12: Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (NQF #0450), which reflects an important patient safety concern and outcome. Similarly, the MAP conditionally supported the Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy measure. This outcome measures offers important information about the care trajectory of cancer patients who have an admission or emergency department visit for an array of symptoms, including nausea, emesis, anemia, neutropenic fever, diarrhea, dehydration, or pain. We hope CMS will consider the inclusion of these measures no later than FY 2017.

We also recommend that CMS develop measures of risk-adjusted, stage-specific survival rates for various types of cancer (e.g., lung, pancreas, liver, thyroid and esophagus, breast, prostate, colorectal). We would point out that these survival rate measures would not need to be developed "from scratch," as they are routinely used in clinical trials and academic publications.

Requirement for Transparency of Hospital Charges Under the Affordable Care Act

The Consumer-Purchaser Alliance has been supportive of the various CMS data releases (May and June 2013 hospital charge data releases; 2013 physician data requests for information; and the April 2014 physician data releases and data provided on geographic variation in payments and payments per beneficiary) – all representing steps in increasing transparency in our health care system. However charge data, which is rarely paid, does not provide actionable information to consumers. In order to reward high-quality care and pay for value, we need information that identifies variations in cost. Releasing these data will allow purchasers and consumers to see the big picture and better understand the cost of health care.

As noted in the NPRM, we are confident that hospitals will rise to meet the reporting obligations reflected in the Public Health Service Act and that the data will be presented in a consumer-friendly way that is meaningful to purchasers and consumers alike. The Consumer-Purchaser Alliance believes that partnerships between patients and their health care providers must be at the center of a transformed health care system. We encourage hospitals to use insights from patients and families to develop price transparency programs. Hospitals, with their unique understanding of their communities and the patients served within them, have the opportunity to serve as a resource for information.

ⁱ The Dartmouth Institute for Health Policy and Clinical Change. *Using Patient-reported Information to Improve Health Outcomes and Health Care Value: Case Studies from Dartmouth, Karolinska and Group Health, 2012*. Available at http://tdi.dartmouth.edu/images/uploads/tdi_tr_pria_sm.pdf.

ⁱⁱ Agency for Healthcare Research and Quality. *Healthcare Cost and Utilization Project (HCUP)*. Available at <http://www.hcup-us.ahrq.gov/databases.jsp>.

ⁱⁱⁱ Sakala C and Corry M. *Evidence-Based Maternity Care: What it is and what it can achieve*. Milbank Memorial Fund, 2008.

^{iv} U.S. Department of Health and Human Services. *New HHS data show quality improvements saved 15,000 lives and \$4 billion in health spending*. Available at <http://www.hhs.gov/news/press/2014pres/05/20140507a.html>.

^v Centers for Medicare and Medicaid Services. *Medicare Hospital Quality Chartbook: Performance Report on Outcome Measures, 2013*. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/-Medicare-Hospital-Quality-Chartbook-2013.pdf>

^{vi} Fierce Healthcare. *Essential hospitals reduce patient harm, costs through national initiative*, July 18, 2013. Available at <http://www.fiercehealthcare.com/press-releases/essential-hospitals-reduce-patient-harm-costs-through-national-initiative>.

^{vii} U.S. Department of Health and Human Services. *New HHS data show quality improvements saved 15,000 lives and \$4 billion in health spending*. Available at <http://www.hhs.gov/news/press/2014pres/05/20140507a.html>.

^{viii} National Quality Forum (NQF), *Serious Reportable Events in Health Care – 2011 Update: A Consensus Report*, Washington, DC: NQF; 2011.

^{ix} The Joint Commission. *Facts about the Sentinel Event Policy*. Available at <http://www.jointcommission.org/assets/1/18/Sentinel%20Event%20Policy.pdf>.

^x HealthDay News. *Blood Infections Play Role in Up to Half of Hospital Deaths*, May 19, 2014. Available at <http://consumer.healthday.com/infectious-disease-information-21/misc-infections-news-411/blood-infections-play-role-in-up-to-half-of-hospital-deaths-687819.html>

^{xi} American Academy of Pediatrics. *Policy statement on breastfeeding and the use of human milk*. *Pediatrics*, 2014 March; 129 (3): e827 -e841

^{xii} American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. *Obstetric care consensus no. 1: safe prevention of the primary cesarean delivery*. *Obstet Gynecol*, 2014 March; 123 (3): 693-711

^{xiii} AWHONN. *Education and Resources: Women's Health and Perinatal Nursing Care Quality Draft Measure Specifications*. Available at https://www.awhonn.org/awhonn/content.do?name=02_PracticeResources/02_perinatalqualitymeasures.htm