

Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.

June 13, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS-1677-P: Proposed Changes to the Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices.

Dear Ms. Verma:

The 20 undersigned organizations represent a collaboration of leading consumer, employer, and purchaser organizations committed to improving the quality and affordability of health care through value-based payment and care delivery, effective measurement, and transparency. Robust value-based accountability programs built on high-value performance measurement can drive quality improvement, inform consumers, and guide payment. We appreciate the opportunity to submit comments to CMS on the proposed changes to the FY 2018 Medicare Inpatient Prospective Payment System (IPPS) rule.

The Medicare hospital quality reporting and payment programs are a critical component in advancing the goals of value-based payment and care delivery throughout the U.S. health care system. As in previous years, we commend CMS's leadership in its ongoing implementation and refinement of federal hospital programs that seek to achieve the goals of the National Quality Strategy through increased transparency and the promotion of payment that rewards quality care rather than volume. However, these programs can be made stronger and more patient-centered through better measurement and transparency. Below we offer comments on strategic issues affecting these programs.

Effective Programs Need High-Value Measures

Our comments on the proposed rule stem from our shared vision for an effective, efficient, and patient-centered health care system.¹ To contribute to such a system, CMS's accountability programs need high-

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

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value measures – that is, those that are meaningful, important, actionable – and need to be free of other low-value measures. Inclusion of low-value measures diminishes the impact of high-value measures. The measure “clutter” from low-value measures also contributes to the administrative and reporting requirements facing providers; in contrast, a program tailored with only the highest value measures will encourage focused improvement and reduce measurement burden overall.

Consumers and purchasers need to be able to use high-value performance information in a way that allows apples-to-apples comparisons among providers. Though most of the hospital programs have uniform measure requirements, the EHR Incentive Program for Eligible Hospitals is a notable exception: hospitals are required to report a certain number of measures but are allowed to choose which specific measures to report from a larger menu of options. This menu approach makes it difficult to compare hospitals consistently, and creates an inappropriate incentive for hospitals to choose measures where their quality is already high instead of in areas where they have most room to improve. Allowing multiple similar measures in a single clinical area within a program with a menu approach (e.g., four nutrition measures are proposed for future consideration in the EHR Incentive Program) compounds the difficulty in understanding a hospital’s overall quality of care.

We share CMS’s interest in reducing unnecessary burdens within the health care system to make the system more effective, simple, and accessible. However, we urge caution in making any changes to CMS’s programs to reduce burden without considering the tradeoffs in availability of information. We cannot operate in an environment with no quality information while we wait for ideal measures to be developed, tested, and put into use. In evaluating possible changes, particularly to performance measures, we strongly urge CMS to assess the value of the information provided by a measure together with the effort required to capture and report the measure.

Addressing Social Risk in Accountability Programs

As required by the 21st Century Cures Act, CMS has proposed an approach to stratifying hospital readmissions performance for the Hospital Readmissions Reduction Program (HRRP). We support this approach and have further comments about the specific proposal in the appendix below. It is appropriate to account for the differing needs of patient populations in payment to ensure that safety net hospitals and other providers that care for vulnerable populations have sufficient resources to deliver high-quality, patient-centered, effective care.

However, we oppose risk adjustment for social factors (e.g., income, race and ethnicity) in the calculation of performance measures. Building social factors into the risk adjustment methodology for performance measures will mask the disparities in care and outcomes across vulnerable populations. It implicitly promotes the concept that poorer care and outcomes are acceptable for patients with greater social risk factors. Accountability programs can instead promote improved care and outcomes for all

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

patients by addressing the differential resources needed to care for patients through payment methodologies such as the proposed stratification in HRRP. This approach avoids adjustment of the performance measures that could, in turn, obfuscate our ability to determine real-world disparities in care.

We strongly oppose risk adjustment for social factors in patient safety measures, including payment programs focused on reducing patient harm like the Hospital-Acquired Condition Reduction Program (HAC Reduction Program). It is unacceptable for patients with social risk factors to experience more preventable blood stream or surgical site infections, more accidental punctures or lacerations, more “never events,” or a higher incidence of other serious events assessed by patient safety measures. Safe care should be a consistent and universal expectation for all patients.

Additional Comments

In the appendix below, we offer detailed comments related to the following sections of the proposed rule:

- Hospital Inpatient Quality Reporting Program (IQR)
- Hospital Value-Based Purchasing Program (HVBP)
- Hospital-Acquired Condition Reduction Program (HACR)
- Hospital Readmissions Reduction Program (HRRP)
- PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- Proposed Changes Relating to Survey and Certification Requirements

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 Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org.

Sincerely,

Organizations listed in alphabetical order

The Alliance
Consumers' CHECKBOOK/Center for the Study of Services
Employers Health Purchasing Corporation
The Empowered Patient Coalition
Florida Health Care Coalition
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
Maine Health Management Coalition
Medicare Rights Center
Memphis Business Group on Health
Mid-Atlantic Business Group on Health
Minnesota Health Action Group
Mothers Against Medical Error

National Alliance of Healthcare Purchaser Coalitions
National Coalition for Cancer Survivorship
National Partnership for Women & Families
Northeast Business Group on Health
Pacific Business Group on Health
St. Louis Area Business Health Coalition
Wyoming Business Coalition on Health

Appendix

A. Hospital Inpatient Quality Reporting (IQR) Program

HCAHPS Survey

We support the goal of the proposed updates to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure to dissuade the overuse of opioids and other pain medication. We agree it is important to remove ambiguities in the wording or intent of the questions and appreciate that CMS has taken steps to appropriately test the measure for reliability and validity. We encourage CMS to refine the measure, in future updates to the measure or via other means, to include patients' assessment of (1) the degree to which hospital staff listened to them and responded to their pain (including offering non-opioid or non-medication options) and (2) the degree to which patients feel the hospital staff helped them understand their options to manage pain. For example, HP3: "During this hospital stay, how often did hospital staff talk with you about how to treat your pain?" could be revised to incorporate one or both of these concepts of care quality for pain management.

Quality of Informed Consent Documents

We strongly support the proposal to include a measure of informed consent quality in the IQR program. Informed consent is critical to the delivery of high-quality patient-centered care. Often, the importance of informed consent is understood too narrowly as a tool to prevent a consumer from having something done to them without their permission. Informed consent is a key outcome of shared-care planning, in which consumers identify the best course of action from all relevant options based on their medical and personal goals. This measure addresses a high-priority measure gap; the consumer and purchaser community has long-awaited a measure that captures the quality of informed consent. We commend CMS for the process used to develop the informed consent document measure proposal. Patients, family caregivers, and advocates were formally engaged from the beginning and all through the measure's development. Meaningful partnerships with patients, families, and consumer advocates as early as possible in the measure development process, including in the prioritization and re-evaluation of measures, will ensure their unique insights and perspectives bring value to the process, ultimately resulting in a more patient-centered performance measurement enterprise.

We support the recommendation to implement this measure immediately. We would also urge CMS to quickly strengthen the measure to ensure that patients' needs and well-being are central. We echo the concerns of other consumer and purchaser groups, and encourage CMS to refine the measure and its proposed implementation in the following ways:

- Introduce a mechanism to ensure good patient experience with the process for gathering signatures on the consent form.
- Ensure the informed consent document captures information on the risks and benefits of the procedure specifically as performed by that provider in that setting.
- Require a longer interval of time between signature and elective procedure. The current measure gives credit for a patient signature obtained 24 hours before a procedure; this may not be sufficient time for a measured consideration of the risks and benefits of a particular

procedure. We recommend a longer interval of time for initial consent, such as 3 or more days, and the addition of a verification of consent immediately before the procedure.

- Implement a consistent, defined process for CMS data validation of abstraction results.
- Use a higher bar for meeting the standards of the measure instead of scaling expectations higher over time. While the measure is new to hospitals, carefully scrutinized and validated consent procedures are not. Consent is a critical part of hospital operations, well understood in literature and heavily evaluated by hospital leaders and clinicians.

Measures of End-of-Life Care for Cancer Patients

We support CMS's proposal to add four measures of end-of-life care for cancer patients to the IQR program in addition to the PPS-Exempt Cancer Hospital Quality Reporting program. Our specific comments about these measures appear later in this appendix, under the heading for that program.

Improving Measurement of Perinatal Care

We recommend that CMS add a measure of low-risk cesarean section rate to the IQR program. Measuring and tracking unnecessary cesarean sections is an important step toward improving perinatal care. The Joint Commission's Cesarean Birth (PC-02) all-payer measure is ready to be implemented and would complement the all-payer Elective Delivery measure now in use in IQR (PC-01). PC-02 is NQF-endorsed (NQF #0471) and is a component of The Joint Commission's Perinatal Care Core Set used for facility accreditation. It is also part of the OB/GYN core set recommended by the multistakeholder Core Quality Measures Collaborative and the MAP Medicaid Child Core Set. Healthy People 2020 includes a benchmark for this measure, which is being used for quality improvement (e.g., in a quality collaborative of about 100 California hospitals).

If included, we recommend that the measure be paired with a balancing measure developed for this purpose, Unexpected Newborn Complications (NQF #0716), a measure of complications arising during labor or in the hospital stay after birth in low-risk newborns. This measure is intended to capture unintended harm due to inappropriately avoided cesareans. The measure received 100% support from the NQF Perinatal and Reproductive Health Standing Committee in 2016.

B. Hospital Value-Based Purchasing (HVBP) Program

PSI-90 and the Patient Safety and Adverse Events Composite

We strongly support the inclusion of the Patient Safety and Adverse Events Composite in the HVBP program as soon as possible. Though we understand the timeline limitations of the authorizing statute that led to CMS's proposal to include this measure in 2023 and beyond, we are disheartened that the removal of PSI-90 due to technical challenges with ICD-9 and ICD-10 codes will mean that CMS's signature value-based payment program lacks a critical patient safety composite for the next five years. We urge CMS to look more broadly for opportunities to accelerate the inclusion of the updated Patient Safety and Adverse Events Composite into the HVBP Program, or include other available measures to ensure that surgical complications remain a key component of the VBP Program.

Pneumonia Episode Payment Measure

We support the proposed addition of a Pneumonia payment measure to the Efficiency and Cost Reduction domain starting in FY 2022, and encourage CMS to consider additional measures of high-impact conditions such as stroke and diabetes. High-impact conditions should be monitored alongside data that shows volume of procedures in an effort to identify geographic areas and providers where volume may be unduly high so that potential issues related to appropriateness and overuse should be addressed.

Efficiency and Cost Reduction Domain

We applaud CMS for prioritizing total cost of care in the proposed weighting methodology for the Efficiency and Cost Reduction domain, as these measures encourage providers to consider the resource use implications of their hospital and specialist referral patterns. We support the proposed methodology to assign a cumulative weight of 50% to the Medicare Spending Per Beneficiary (MSPB) measure and to allocate the remaining percentage equally among the remaining discrete episode-based spending measures.

C. Hospital-Acquired Condition Reduction (HACR) Program

Accounting for Social Risk in the HACR Program

As noted above, we do not support any adjustment for social risk factors to patient safety measures or patient safety accountability programs focused on reducing harm to patients, including the HACR Program.

Medication Reconciliation: Unintentional Medication Discrepancies (NQF #2456)

We recommend for immediate implementation Medication Reconciliation: Unintentional Medication Discrepancies (NQF #2456). The measure calls for hospitals to sample 25 adult inpatients per quarter and have a licensed pharmacist create a 'gold standard' preadmission medication list (PAML), which is then compared to the medication list from admission and to the medication list on discharge. Hospitals report on the number of unintentional medication discrepancies identified between the PAML and the admission and discharge orders, resulting in a rate of unintentional medication discrepancies per patient. This measure goes beyond the current medication reconciliation measures required by CMS or The Joint Commission to truly measure outcomes of a hospital's medication reconciliation process.

D. Hospital Readmissions Reduction Program

Stratifying Readmissions Performance by Proportion of Dual Eligible Patients

We support CMS's work to establish peer groups among participating hospitals for the purpose of payment, in accordance with 21st Century Cures Act. Specifically, we support the approach to stratify

hospitals into quintiles, and encourage CMS to use both Medicare FFS and Medicare Advantage hospital stays in calculating readmission rates.

However, we oppose risk adjustment for social factors at the individual measure level (e.g., when calculating readmission rates) and for public reporting. We support transparency in measure calculation and stratification of payment as a way to ensure high quality for all patients, and fair and sufficient payment to safety net hospitals and other providers caring for patients with unmet needs.

E. PPS-Exempt Cancer Hospital Quality Reporting Program

Measures of End-of-Life Care for Cancer Patients

The quality of care at the end of life is a significant measurement gap in the current programs. We support CMS's proposal to address this gap by adding four measures that evaluate end-of-life processes and outcomes for cancer patients:

- Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life measure (NQF #0210);
- Proportion of Patients Who Died from Cancer Not Admitted to Hospice measure (NQF #0215);
- Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life measure (NQF #0213); and
- Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days measure (NQF #0216).

We are satisfied with the strong evidence behind these measures. These measures have potential to improve care, including patient and caregiver experience, by incentivizing hospice use and discouraging unnecessarily aggressive treatment in the last days of life. We respect the critical importance of ensuring a more humane approach to patients as they near the potential end of life, as well as the necessity of full patient and family engagement in decision-making about all aspects of care.

At the same time, we encourage CMS to pair these utilization measures with measures of shared care planning, such as an assessment of how closely care received aligns with patient preferences and goals. Though the goal of these utilization measures is to avoid unnecessarily aggressive care, they may be seen as incentives to stint on necessary or beneficial care that aligns with a patient's goals.

We strongly agree that risk adjustment and risk stratification are not appropriate for the proposed measures as the goal is to assess the quality of care provided to all cancer patients at the end of life.

F. Proposed Changes Relating to Survey and Certification Requirements

Proposed Revisions to the Application and Re-Application Procedures for National Accrediting Organizations, Provider and Supplier Conditions, and Posting of Survey Reports and Acceptable Plans of Corrections

We strongly support CMS's proposal to increase transparency by requiring private, national accrediting organizations to make all survey reports and acceptable plans of correction publicly available. The present situation represents a double standard, as hospitals may choose to be surveyed by either State agencies or private organizations and State survey agencies are required to publicly report survey results but private accrediting organizations are not.

Consumers deserve to have access to all accreditation survey findings, including initial survey findings, accepted plans of correction, and follow-up survey findings after remedial action has been taken. This change can improve transparency about health care performance across the nation, bringing parity in public information between facilities that are deemed by private accrediting organizations and those that use a state survey agency.