Consumer-Purchaser
ALLIANCE
Better information. Better decisions. Better health care.

June 25, 2018

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

RE: [CMS-1694-P] RIN 0938-AT27 Medicare Program; 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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Administrator Verma:

The 19 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. We appreciate the opportunity to submit comments to CMS on the proposed changes to the FY 2019 Medicare Inpatient Prospective Payment System (IPPS) rule and commends 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. Robust value-based accountability programs built on high-value performance measurement can drive quality improvement, inform consumers, and guide payment; 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. Transformation efforts must also prioritize patient experience and strategies for meaningful patient engagement, which includes shared decision-making informed by individuals' goals, life circumstances and desired outcomes.

We support the intent of the proposed health information technology (HIT) policies to create a patient-centered health care system that promotes greater price transparency, interoperability and overall value; and, we agree that improving consumers' access to cost, quality and clinical information is critical to achieving a transformed health care system. We are concerned, however, that the current proposals to reduce duplication and reduce reporting burden throughout CMS's hospital programs will

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compromise the assurance of uniform, granular and easily understandable performance information for public use now and in the future, and will impact CMS's goals of incentivizing and rewarding high-quality care. We urge CMS to maintain the Hospital Value-Based Purchasing (HVBP) program measures in the IQR to ensure critical outcomes information is not lost to consumers and other health care stakeholders (e.g., admitting physicians) and to maintain the HACRP measures in the HVBP to ensure that all hospitals are accountable for patient safety (e.g., hospital-acquired conditions, errors resulting in patient harm). In the Appendix, we offer CMS recommendations for balancing the needs of all stakeholders while promoting high-value and high-quality care through its federal programs.

Additionally, we applaud CMS's initiative in soliciting stakeholder input through the requests for information (RFIs) on promoting interoperability and price transparency for consumers. We strongly urge CMS to undertake similar outreach and engagement efforts for the new Meaningful Measures initiative to ensure that implementation of the Framework across CMS's accountability programs (e.g., evaluations of current measure sets, identification of gaps to move toward higher value measures) is informed by and reflects the needs of all health care stakeholders. [1] In the Appendix, we offer our input on the two RFIs and our recommendations on how the Meaningful Measures initiative can be applied to federal hospital programs to meet the needs of all stakeholders, including consumers and purchasers.

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 Bill Kramer, co-chair for the Consumer-Purchaser Alliance, at wkramer@pbgh.org.

Sincerely,

The Alliance
American Association on Health and Disability
Disability Rights Education and Defense Fund
The Economic Alliance for Michigan
The Empowered Patient Coalition
Health Policy Corporation of Iowa
HealthCare 21 Business Coalition
Lakeshore Foundation
The Leapfrog Group
Memphis Business Group on Health
MidAtlantic Business Group on Health
National Alliance of Healthcare Purchaser Coalitions
National Coalition for Cancer Survivorship
National Partnership for Women & Families
Nile's Project MRSA
Pacific Business Group on Health

[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 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."

Pulse of Colorado
St. Louis Area Business Health Coalition
Wyoming Business Coalition on Health

Appendix

A. The Proposed Removal Factor 8 for the Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program

Factor 8: "The costs associated with a measure outweigh the benefit of its continued use in the program"

We are happy to see CMS framing measurement in terms of value and not just burden, however the assessment of value must be as transparent as possible with a clear prioritization of the needs of patients/consumers. We strongly urge CMS to develop a standardized evaluation and scoring system with significant multi-stakeholder input, to ensure that Factor 8 appropriately balances the needs of all health care stakeholders. As it is currently proposed, we do not support the adoption and use of Factor 8 in any of CMS's programs due to lack of transparency around assessment criteria. We, therefore, do not support those proposals to remove measures which cite Factor 8 as the primary reason.

Measurement and monitoring of quality, outcomes and safety is required in virtually every other industry and is a key responsibility for health care providers as well. Any assessment of the cost of continued use of a given measure must account for this responsibility – cost assessments should not only consider the reporting method (e.g., eCQMs, claims-based) but also whether a more efficient alternative is available to collect the performance data. Any assessments of the benefits of continued use of a given measure must account for the public's right to quality and cost transparency and consumers' reliance on publicly available information to make important healthcare decisions, in addition to the potential impact of the measure on improving care quality (e.g., size of performance gap). For example, some aspects of care quality require continuous monitoring because they are essential to high-quality patient care and/or have serious consequences if done poorly (e.g., patient safety, patient experience). Such measures should never be removed from payment programs designed to incentivize and reward high-quality, even if the measures are topped out.

We appreciate CMS's intent in the new Meaningful Measures Initiative to drive towards high-value performance measurement through the implementation of harmonized sets of performance measures; the information obtained from such measurement should drive improvements in quality, provide meaningful information for consumer decision-making, and provide useful information for value-based payment and purchasing by CMS and other purchasers. We are concerned that the Meaningful Measures initiative is being implemented without sufficient multi-stakeholder input. We urge CMS to more meaningfully and consistently engage consumers and purchasers (among other stakeholders) to inform the initiative's goals, principles, and application across CMS's provider payment and reporting programs. This could be achieved through a multi-stakeholder steering committee that has a majority of consumers and purchasers representing the end-users of the health care system.

B. Streamlining Measures Across CMS's Hospital Accountability Programs

While the inclusion of performance measures in multiple CMS hospital programs may appear to be excessively duplicative, CMS's programs have unique yet complementary objectives to ultimately achieve the goals of the National Quality Strategy through increased transparency and the promotion of payment that rewards quality care rather than volume:

- The Hospital Readmissions Reduction Program penalizes hospitals performing under the average of all hospitals[2] up to 3% of the annual base fee-for-service (FFS) payment based on their rate of excessive readmission rate (ratio of predicted to expected readmissions rate for any given measure);
- The Hospital-Acquired Conditions Reduction Program penalizes the lowest performing quartile of hospitals by withholding up to 1% of the annual base FFS payment;
- The Hospital Value-Based Purchasing Program rewards or penalizes hospitals up to 2% of their annual base FFS payment based on quality and cost performance, as a budget neutral program designed to continuously promote better clinical outcomes and patient-experience system-wide; and
- The IQR program withholds 1/4th of the increase to a hospital's Annual Payment Update for the applicable fiscal year for failure to meet reporting requirements; and, is the primary vehicle for ensuring that hospital performance information is available to the public in a unified and easily understandable manner on Hospital Compare.

We urge CMS to prioritize investments in long-term technical (and policy) solutions to reduce administrative reporting costs that would enable more efficient performance reporting without compromising the public's right to provider performance information. For example, a solution to allow hospitals to report on a measure once for use in multiple accountability programs would negate the issue of measure duplication. Aligning performance periods (e.g., between the HVBP and IQR) would mitigate the issue of multiple, potentially confusing scoring reports for hospitals participating in more than one CMS program. The proposed approach of removing duplicate measures would drive the system away from its goals to make quality more transparent for all stakeholders.

- ***Addressing duplication across public reporting and payment programs***

By statute, the Inpatient Quality Reporting (IQR) program is the primary vehicle for incentivizing hospitals to report complete and valid quality data and for ensuring that hospital performance information is available to consumers and other health care stakeholders. Virtually all hospitals are represented in IQR and, therefore, are accountable to the public.

It is not appropriate to streamline measures across public reporting and value-based payment (VBP) programs given their fundamentally different goals. IQR serves as the foundation for other CMS quality programs by providing a financial incentive for hospitals to report complete and valid quality data (which is then used in the other CMS VBP programs). Already, these proposals have obligated CMS to take a fragmented approach in ensuring data integrity within the design of each of the three value-based payment programs. However, the proposed approach for the HAC program to incentivize data integrity does not directly penalize hospitals that fail the data validation process, as the IQR program does. We urge CMS to maintain all of the previously finalized measures in the IQR program, so that CMS's VBP programs are built on a strong foundation of performance data.

We have significant concerns that removing measures from IQR will create skewed incentives for hospitals to report quality data. For example, under the current proposal and given the downside-only

[2] Starting in CY2019, hospitals will be stratified into 5 peer groups based on proportion of dually eligible Medicare patients (rather than compared across all Medicare hospitals), so payment determinations will be based on a hospital's peer group average

incentive structure for the HAC program, hospitals would be faced with the choice to either collect and submit patient safety data to determine whether they are subject to a penalty or avoid data collection altogether – and the subsequent public reporting of data – and take the (now reduced) financial penalty. We are concerned that these incentives would reduce the availability of data on patient safety and adverse events for all stakeholders, impacting quality transparency as well as quality improvement/monitoring efforts. We strongly urge CMS to maintain the measures currently proposed for removal due to duplication with the HAC program; it is not appropriate to compromise the availability of patient safety data for the purposes of reducing the administrative costs/complexity associated with performance measurement. The following measures have been inappropriately proposed for removal from IQR because of duplication with the HAC program:

- Catheter-associated urinary tract infection outcome measure[3]
- Facility-wide inpatient hospital-onset Clostridium difficile infection outcome measure
- Central line-associated bloodstream infection outcome measure
- Harmonized procedure specific surgical site infection (SSI) outcome measure
- Facility-wide inpatient hospital-onset MRSA bacteremia outcome measures
- Patient safety and adverse events composite

Removing measures from IQR also threatens the assurance of measure-level data, reported in an accessible and easily understandable way for public use. For example, the Hospital Value-Based Purchasing (HVBP) program reports hospital performance at the domain-level rather than at the measure-level. Moreover, public reporting of a hospital's performance score in a payment program is not a substitute for reporting measure-level results because scoring approaches intended for payment can be misleading. The HVBP scoring approach allows for the greater of an improvement or achievement score to be used to represent each quality measure so domain-level scores are not useful for patients and other stakeholders to make comparisons.

We urge CMS to prioritize the public's right to quality transparency by driving toward increasingly granular and meaningful performance information, which enables patients and other health care stakeholders (e.g., admitting physicians) to assess specific hospitals for certain procedures based on the specific needs and priorities of the patient. CMS should not finalize any proposals that compromise the public's access to performance information, including the frequency of reporting, the granularity of information, and the intelligibility of information presented for public use. CMS should, at a minimum, ensure that measure-level results continue to be reported on Hospital Compare for all measures in the Hospital VBP program to ensure that there is no loss of information to the public. The following measures have been inappropriately proposed for removal from the IQR because of duplication with the Hospital VBP program:

- Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty
- Hospital 30-day, all-cause, risk-standardized mortality rate following acute myocardial infarction (AMI) hospitalization
- Hospital 30-day, all-cause, risk-standardized mortality rate following coronary artery bypass graft (CAG) surgery

[3] We recognize that proposals have been submitted to the National Quality Forum (NQF) suggesting different ways to measure and apply the measure for catheter-associated urinary tract infections for persons with spinal cord injury

- Hospital 30-day, all-cause, risk-standardized mortality rate following chronic obstructive pulmonary disease (COPD) hospitalization
- Hospital 30-day, all-cause, risk-standardized mortality rate following heart failure (HF) hospitalization
- Hospital 30-day, all-cause, risk-standardized mortality rate following pneumonia (PN) hospitalization
- Hospital 30-day, all-cause, risk-standardized mortality rate following stroke hospitalization* (removal rationale cites the 8th removal factor and that measure data is captured under a more broadly applicable measure (hospital-wide readmissions))

We strongly urge CMS to keep the measures listed above (both HAC measures and HVBP measures) in the IQR program to ensure continued public access to critical, condition-specific outcomes information. This would also maintain the integrity of the IQR program, compared to a more fragmented solution of modifying the public reporting requirements for each of CMS's programs (e.g., the HVBP) to require uniform, measure-level reporting on Hospital Compare. For these reasons, we encourage CMS to maintain all previously adopted patient safety and other outcomes measures in the IQR program to ensure public access to granular, high-value performance information and to ensure that future improvements in public reporting (e.g., new formats that clarity and usability of information, new high-value measures) can be adopted evenly and swiftly across all publicly reported measures.

- ***Addressing duplication across federal hospital payment programs***

The three CMS hospital value-based payment programs are designed to be complementary in promoting better clinical outcomes and improved patient experience. We strongly urge CMS to maintain the measures currently duplicated in the HACRP and HVBP in both programs, as well as in the IQR program for public reporting assurances. Any assessment of hospital quality must include patient safety and account for adverse events (i.e., healthcare errors resulting in patient harm). The HACRP's payment structure does not appropriately incentivize medium- to high-performing hospitals to reduce or eliminate the occurrence of adverse events and sends the message that mediocre performance on hospital safety measures is acceptable. The following measures have been inappropriately proposed for removal from the HVBP program due to duplication in the HACRP:

- Catheter-associated urinary tract infection outcome measure[4]
- Facility-wide inpatient hospital-onset Clostridium difficile infection outcome measure
- Central line-associated bloodstream infection outcome measure
- Harmonized procedure specific surgical site infection (SSI) outcome measure
- Facility-wide inpatient hospital-onset MRSA bacteremia outcome measures
- Patient safety and adverse events composite

We urge CMS to maintain the measures listed above in the HVBP to ensure that all hospitals are incentivized to prioritize patient safety in their quality improvement strategies.

C. PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

[4] We recognize that proposals have been submitted to the National Quality Forum (NQF) suggesting different ways to measure and apply the measure for catheter-associated urinary tract infections for persons with spinal cord injury

We strongly support the proposal to adopt the 30-day Unplanned Readmissions for Cancer Patients measure (NQF #3188), which will promote higher-value care for cancer patients and fills an important gap in the PCHQR program.

However, we do not support the application of Factor 8 to measures in the PCHQR program. We are concerned that consumers' needs have not been appropriately factored into the value assessment of Catheter-Associated Urinary Tract Infection (CAUTI) Outcome measure (NQF #0138) and the Central Line-Associated Bloodstream Infection (CLABSI) Outcome measure (NQF #0139), and strongly oppose the removal of these measures from the PCHQR program.[5] It is critically important that PCHQR facilities be held accountable for these events and for solutions to be developed to enable public reporting of these measures.

D. Promoting Interoperability Program (PIP)

Overall, we applaud the focus on interoperability and patient access in the proposed rule. We believe widespread electronic exchange of health information is a prerequisite for reimbursing value-based care and improving health outcomes. However, we are concerned that the removal of the complementary patient engagement measures will limit the effectiveness of the program to promote meaningful improvements in interoperability. We do not support the proposals to eliminate measures that help patients and family caregivers to use their online health information (*View/Download/Transmit*), communicate electronically with providers (*Secure Messaging*) and contribute information to their medical record that is specific and material to their care (*Patient Generated Health Data*). For example, patients with functional impairments can provide extremely valuable information to their providers about the kinds of accommodations that are essential to effective examination/care and communication (e.g., height-adjustable exam tables, American Sign-Language interpretation).

We urge CMS to reinstate these measures of active patient engagement. Without these measures, providers have little incentive beyond "turning on" data access to proactively inform patients and caregivers about what information is available and how receiving and providing information can be used to better manage their health.

- ***2015 Edition Certified Electronic Health Record Technology (CEHRT)***

We strongly support the requirement to transition to the 2015 Edition of Certified Electronic Health Record Technology (CEHRT), which enables critical functionalities that are foundational to a patient- and family-centered health care system, including application programming interfaces (APIs) for consumer access, more robust demographic data collection, and information on social determinants of health. Collecting and using this information not only has clinical relevance, but also is vital for improving health outcomes and enhancing health equity. For example, collection of granular demographic information (e.g., disability, gender) is increasingly recognized through research and will enable providers to address racial, ethnic, disability and gender disparities. We encourage CMS to develop corresponding measures encouraging providers to use these and other person-centered functionalities enabled in the 2015

[5] We recognize that proposals have been submitted to the National Quality Forum (NQF) suggesting different ways to measure and apply the measure for catheter-associated urinary tract infections for persons with spinal cord injury

CEHRT, such as care plans and links to community resources and supports, in future performance years of the PIP.

- ***Health Information Exchange Objectives and Measures***

We appreciate the focus on health information exchange in the PIP and support the proposal to heavily weight these measures to emphasize the importance of information sharing. Specifically, we support CMS's intention to preserve measures that encourage providers to receive and incorporate health information from other providers (in addition to sending information), and the necessary information reconciliation activities that accompany these efforts. These activities are at the heart of improved care coordination and health outcomes, and address consumer priorities for better communication between providers. We underscore the importance of information reconciliation as a prerequisite for safe, high-quality care, as well as a valuable opportunity to engage patients and caregivers in their health and care. Finally, we strongly support CMS's intention to pursue measures in future years that promote the electronic exchange of health information to improve care coordination across a range of settings.

E. Interoperability RFI

We support the goal of achieving widespread electronic exchange of health information across the health care spectrum. We believe data is a shared resource, rather than a competitive asset, and information that supports/enables optimal care (i.e., tailored to the patient's individual needs and priorities) must be available to those who care for the patient – including the patient themselves. Moreover, interoperability is critically needed to improve health care system efficiency and to reduce hospital overhead costs. We appreciate that this Administration is committed to bold action to advance interoperability and to support efforts that increasingly enable patients and their providers to seamlessly access and share their digital health information.

F. Consumer Price Transparency RFI

We are encouraged by CMS's proposal to improve consumers' access to price information by requiring hospitals to post standard charges online. However, given that these charges are not reflective of what consumers ultimately pay, patients and families also deserve individualized estimates of out-of-pocket costs in advance of services, including information on deductibles, co-insurance and copayments. Moreover, this type of individualized cost information can support more effective and pragmatic shared care planning discussions. We agree that CMS should assess hospital compliance and publicize those hospitals that fail to publicly post and annually update standard charges in a user-friendly format online.

Cost information should always be supplemented with data on provider quality and health outcomes to prevent their conflation, as consumers may be led to believe that higher prices are indicative of better quality care. Given the significant variability in quality and cost of care, consumers should not have to bear a significant proportion of health care costs (e.g., through high-deductible health plans or consumer-directed health plans, value-based insurance design) without greater transparency in provider cost and quality to inform those key healthcare decisions.