



June 16, 2015

Mr. Andy Slavitt  
Acting Director  
Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services (HHS)  
**Attention: CMS-1632-P**  
200 Independence Avenue, SW  
Washington, DC 20201

**RE: Proposed Rule for the Hospital Inpatient Prospective Payment Systems (IPPS)  
for Acute Care Hospitals and Fiscal Year 2016 Rates (Docket Number CMS-1632-P)**

Dear Acting Director Slavitt:

The National Business Group on Health appreciates the opportunity to comment on CMS' proposed IPPS changes for acute care hospitals for 2016. We applaud your leadership and that of the Secretary in pledging to accelerate Medicare's move toward alternative payment models and to basing the remaining fee-for-service (FFS)-based payments on value. As Medicare advances toward alternative payment methods and paying for value, it reinforces and facilitates the private sector's ability to do so.

The proposed refinements to the hospital-based pay for performance program, quality-reporting requirements, and electronic health record (EHR) incentive program are key steps toward increasing Medicare's transitioning of FFS to payment for value. Therefore, we strongly support them. Specifically, we support:

- Adding the proposed total hip and/or total knee replacement safety measure and the coordination of care measures for acute myocardial infarction (AMI) and congestive heart failure (CHF) to the Inpatient Quality Reporting Program.
- Adding a care coordination measure for reporting in 2016 and payment in 2018, and, beginning in 2021, reporting 30-day mortality for chronic obstructive pulmonary disease (COPD) to the Value-Based Purchasing Program.
- Refining the pneumonia measure and adding coronary artery bypass graft (CABG) to the Readmission Reduction Program.
- Expanding the central line-associated bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) measures to include patients outside the ICU.

Equally important, we support the proposed efforts to expand measures of cost and efficiency in the Value-Based Purchasing Program beyond Medicare Spending per Beneficiary. Such measures are as critical to moving Medicare to paying for value as measures of quality and are particularly important to controlling unnecessary Medicare expenses. Specifically, we recommend adding the following risk-standardized National Quality Forum (NQF)-endorsed measures:

- Hospital-level payment associated with 30-day episode of care for AMI,
- Hospital-level payment associated with 30-day episode of care for CHF, and
- Hospital-level payment associated with 30-day episode of care for pneumonia.

The National Business Group on Health represents approximately 420 primarily large employers, including 70 of the Fortune 100, who voluntarily provide group health plan coverage and other health programs to over 55 million American employees, retirees and their families.

What Medicare does to improve efficiency and quality will have a valuable spillover effect for our health care delivery system, the health of the population and the nation's economy. We look forward to continuing to work with you to transition our nation's health care system to one based on value, quality and health improvement. Again, thank you for the opportunity to comment. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail.

Sincerely,

A handwritten signature in black ink that reads "Brian Marcotte". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

Brian Marcotte  
President and CEO

## **Addendum**

### **Adding Measures to the Hospital IQR Program:**

In addition to the increase in payment for reporting, the expansion of reporting to add care coordination measures for AMI and CHF and a patient safety measure for total hip and/or total knee replacement would provide critical information on key aspects of quality for these high cost, high volume conditions.

Given the underlying chronic nature of cardiovascular disease and heart disease, and the multiple providers, post-acute services, and medications involved in caring for these patients post-discharge, and given the strong likelihood of comorbidities and complications, reporting measures of care coordination for AMI and CHF patients is vital to improving quality.

Similarly, given the risk of complications involved with total knee and total hip replacement, both in the hospital and post-discharge, requiring reporting of hospital-level risk-standardized payment associated with an episode of care for elective total hip and/or total knee replacement will provide useful information on safety.

### **Adding Measures to the Hospital Value-Based Purchasing Program:**

The current Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey only asks discharged patients to where they were discharged, if providers discussed whether they would need help after leaving and if they gave patients information on symptoms to watch for. Adding a measure consisting of three questions on care transitions to the HCAHPS patient satisfaction survey, centered on the discharge process—understanding their medications, what they need to do post-discharge to manage their health, and whether the hospital staff took into account the patient’s preferences in determining health care needs after discharge—are all important elements to not only assess the quality of the discharge process, but to reduce complications, readmissions, and other adverse health consequences after discharge.

Expanding the measures to include 30-day mortality for COPD in 2021 will increase incentives for hospitals to better manage this chronic condition for patients after discharge to avoid visits to the emergency room and readmissions.

### **Changes to the Hospital Readmissions Reduction Program**

We support CMS’ proposal to expand reimbursement penalties for excess avoidable readmissions of pneumonia patients to include patients with a principal diagnosis of sepsis or respiratory failure who have a secondary diagnosis of pneumonia under the Hospital Readmissions Reduction Program. Under the program, hospitals with excess readmissions 30 days post-discharge for Medicare patients with a principal diagnosis of AMI, CHF, COPD, total knee replacement, total hip replacement or pneumonia may be penalized by CMS with lower reimbursements. Currently, the program only counts

readmissions for those with a principal diagnosis of pneumonia. Often patients with pneumonia are treated in hospitals without a formal diagnosis because hospitals did not take any lab tests to confirm the diagnosis. Prior to the program, many of these patients received a principal diagnosis of pneumonia anyway because of their symptoms. Since the beginning of the program, however, coding for pneumonia has fallen while diagnoses of respiratory failure have increased. Nevertheless, many hospitals treat these patients as if they have pneumonia and may receive a secondary diagnosis of pneumonia. The change would ensure that the program includes the complete population of patients treated for pneumonia.

Adding CABG to the list of conditions in the program would increase incentives for hospitals to improve management and care coordination post-discharge for these patients and help avoid complications leading to readmission, which are all too common for CABG patients.

### **Expanding Measures in the Healthcare-Acquired Conditions Reduction Program**

The CDC estimates that 30,100 CLABSIs occur in ICUs of U.S. acute care facilities each year.<sup>i</sup> They also report that there were an additional 23,000 CLABSIs in non-ICU inpatient wards in 2009<sup>ii</sup>. It makes sense that the program should extend to CLABSIs outside the ICU. Similarly, it makes sense to track CAUTI infections in hospitals outside the ICU as well. Hospitals have procedures to reduce these types of infections and, from the patient's point of view; it is the same infection and same preventable consequences regardless of whether patients' contracted either of them in or out of the ICU.

### **Recommendations for Expanding Measures of Cost and Efficiency in the Value-based Purchasing Program**

As stated in our letter, it is critical that Medicare expand the use and reporting of measures of cost and efficiency. Because CHF, AMI, and pneumonia are common conditions in the Medicare population, payments vary substantially due to practice patterns, hospitals report quality measures for these conditions, they are ideal candidates for care coordination and post-discharge management, and they are conditions targeted in the Hospital Readmission Reduction Program, measures of cost and efficiency associated with these conditions seem apt to recommend for inclusion in the Value-Based Purchasing Program.

Furthermore, hospital-level, risk-standardized payment associated with a 30-day episode of care for CHF, AMI, and pneumonia are endorsed by the NQF. Therefore, we recommend CMS add these measures to the current Medicare Spending per Beneficiary measure.

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<sup>i</sup> CDC National and State Healthcare-Associated Infections Progress Report. March 2014, [http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC\\_CLABScurrent.pdf](http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf)

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<sup>ii</sup> U.S. Centers for Disease Control and Prevention. Vital signs: Central line–associated blood stream infections—United States, 2001, 2008, and 2009. Morbidity and Mortality Weekly Report. March 4, 2011, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6008a4.htm>