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ALLIANCE
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October 3, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-5519-P: Medicare Program; Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)

Dear Administrator Slavitt:

The Consumer-Purchaser Alliance is a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement.[1] We appreciate the opportunity to provide input on the proposed changes to the Medicare Part A and B episode payment models.

A high-value health care system requires value-driven payment arrangements. We applaud CMS for pursuing opportunities to spread value-based payment to more providers through expansion of the mandatory episode payment models (EPMs) beyond lower extremity joint replacement. In addition to broadening the scope of mandatory EPMs, we were pleased to see CMS take steps to align its bundled payment programs with the Advanced Alternative Payment Model (APM) track of the Quality Payment Program (QPP). This alignment effectively strengthens incentives for clinicians to participate in payment models that have the greatest potential to transform the health care system.

To be effective, a value-based payment model must have meaningful quality measures that drive improvement and allow consumers, purchasers, and other stakeholders to evaluate both a provider's performance and the success of the payment model over time. Without these guardrails and other consumer protections, incentives to reduce costs may contribute to stinting on care.[2] The EPM program should use a robust and comprehensive set of high-value measures. The measures CMS has

[1] For brevity, we refer in various places in our comments to "patient" and "care," given that many Medicare Part B programs are rooted in the medical model. People with disabilities frequently refer to themselves as "consumers" or merely "persons." Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.
[2] Jha, A. K. (2016, August 4). JAMA Forum: Will Episode Payment Models Show How to Better Pay for Hospital Care? Retrieved September 22, 2016, from https://newsatjama.jama.com/2016/08/04/jama-forum-will-episode-payment-models-show-how-to-better-pay-for-hospital-care/

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proposed certainly fit our criteria; patient experience and outcomes like mortality are very meaningful to consumers and purchasers. **In addition to the proposed measures, CMS should add measures of the most frequent and egregious complications and errors, other clinical outcomes where possible, and measures based on patient-generated information.** To strengthen the proposed cardiac models, we recommend CMS focus on the highest impact issue areas including medication errors, hospital-acquired infections, and hospital-related injuries. In addition, CMS should incorporate clinician-level measures such as the ACCF/AHA/AMA-endorsed measures for CAD and hypertension that include both symptom management and symptom assessment,[3] or the STS CABG Composite Score that includes medication, operative care process, operative mortality, and morbidity.

We have previously advocated for accountability programs to use a small set of meaningful quality measures in order to ensure that each measure has a substantial impact on a quality score or incentive. We acknowledge that our recommendation to include additional measures would lower the impact of any individual measure and would encourage CMS to consider a quality score weighting such as those described in the two following tables. This approach would maintain a strong emphasis on mortality as a central outcome but would also give weight to other issues that matter to consumers.

MEASURES AND ASSOCIATED PERFORMANCE WEIGHTS IN AMI MODEL COMPOSITE QUALITY SCORE

Quality Measure	Weight in Composite Quality Score	Quality Domain/Weight
MORT-30-AMI	40%	Outcomes – 75%
AMI Excess Days	10%	
Safety and Complications measures	15%	
Hybrid AMI Mortality voluntary data	10%	
HCAHPS	25%	Patient experience and engagement – 25%

MEASURES AND ASSOCIATED PERFORMANCE WEIGHTS IN CABG MODEL COMPOSITE QUALITY SCORE

Quality Measure	Weight in Composite Quality Score	Quality Domain/Weight
MORT-30-CABG	50%	Outcomes – 75%
STS CABG Composite (or other appropriate quality measures)	15%	
Safety and Complications measures	10%	
HCAHPS	25%	Patient experience and engagement – 25%

[3] Joseph Drozda, Jr, MD, FACC, Joseph V. Messer, MD, MACC, FAHA, FACP, John Spertus, MD, MPH, FACC, FAHA, et al., "ACCF/AHA/AMA–PCPI 2011 Performance Measures for Adults With Coronary Artery Disease and Hypertension A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures and the American Medical Association–Physician Consortium for Performance Improvement," *Circulation*. 2011;124:248 –270.

Alternatively, CMS could consider an approach that incorporates safety and complications measures via penalty for falling below a threshold, rather than as a baseline contributor to the quality composite score. This would allow critically important safety issues to be addressed in participants' performance scores even if there is a relatively low incidence of safety problems or complications nationwide.

Beyond these measures, collection and use of patient-generated information is fundamentally important for identifying and improving health care in ways that are meaningful to patients. As we have noted in previous comments, patient-reported outcomes (PROs) provide information that is critically important to patients: their overall quality of life and ability to perform daily activities (i.e., functional status).[4] This information should be used to inform care and treatment plans, and measures based on PROs can help patients and their families, as well as purchasers implementing these programs, to know whether a provider or facility is delivering what matters most to patients. Leaders in cardiovascular care support the use of PROs and patient-reported health status in measuring cardiovascular health. For example, the American Heart Association advocates for patient-reported health status as a valid and important measure of cardiovascular health.[5] **We strongly urge CMS to add an incentive to collect and report PROs for the cardiac EPMs, beginning as pay-for-reporting and evolving to mandatory reporting and pay-for-performance in later years.**[6] We recommend that CMS use three surveys that have been endorsed by the International Consortium for Health Outcomes Measurement (ICHOM) for use in evaluating all patients with coronary artery disease (CAD). Together, this set of surveys addresses three main components of a patient's health status: symptom burden, functional status, and health-related quality of life.[7]

1) **SAQ-7, the short version of the Seattle Angina Questionnaire (SAQ)** – This short-form instrument assesses disease-specific health status among patients with CAD, with properties and performance similar to the full SAQ but with a substantially reduced response burden. This instrument quantifies five important domains affected by CAD: physical limitation, angina stability, angina frequency, treatment satisfaction, and disease perception.
2) **Rose Dyspnea Scale** – This survey quantifies shortness of breath and can be used to enhance the prognostic ability of providers. Dyspnea is a sign of serious disease of the airway, lungs, or heart and requires medical attention.

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[4] Eames Huff, J., & Hopkins, D. (2015, July 23). Patient-Reported Outcomes (Issue brief). Retrieved September 22, 2016, from Consumer-Purchaser Alliance website: http://consumerpurchaser.org/files/CPA_Patient-ReportedOutcomesBrief_05.pdf

[5] Rumsfeld, J. S., Alexander, K. P., Goff, D. C., Graham, M. M., Ho, P. M., Masoudi, F. A., . . . Zerwic, J. J. (2013). Cardiovascular Health: The Importance of Measuring Patient-Reported Health Status: A Scientific Statement From the American Heart Association. Circulation, 127(22), 2233-2249. doi:10.1161/cir.0b013e3182949a2e

[6] We note that pay-for-performance would require the development and inclusion of a validated PRO-based performance measure. We believe that the voluntary and then mandatory collection and reporting of PRO data would enable the development and testing of such a measure in parallel with the first years of this program.

[7] McNamara, R. L., Spatz, E. S., Kelley, T. A., Stowell, C. J., Beltrame, J., Heidenreich, P., . . . Lewin, J. (2015). Standardized Outcome Measurement for Patients With Coronary Artery Disease: Consensus From the International Consortium for Health Outcomes Measurement (ICHOM). Journal of the American Heart Association, 4(5). doi:10.1161/jaha.115.001767

3) **PHQ-2, the short version of the Patient Health Questionnaire-9 (PHQ-9)** – PHQ-2 is a depression screening tool that evaluates an important and often overlooked aspect of patient health. This 2-item tool has the benefit of minimal response burden on patients. However, it is important to ensure that patients who screen positive be further evaluated using PHQ-9 to determine whether they meet criteria for a depressive disorder.

In addition to these three instruments, CMS should include global health surveys in a PROs reporting option for both proposed cardiac models. The information provided by global health surveys is important for accurately documenting patients' perspectives of their overall health status and for tracking health trajectories. We recommend that CMS include the global health surveys currently available for reporting under the CJR program: Veterans RAND 12 Item Health Survey (VR-12) and PROMIS Global Physical Health.

By encouraging the collection and reporting of information from these surveys, CMS can further the development of needed PRO measures to fill gaps in quality improvement and accountability programs. When considering specific data elements to capture, we suggest CMS look to ICHOM and the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Data Standards.[8] Both organizations engaged in rigorous processes to determine which data elements would best support the development and testing of PROMs for patients with coronary artery disease, including review of current research and registries, an expert panel, and a consensus process. CMS may also want to consider, as a reference, its current work on developing a patient-reported outcome measure for percutaneous coronary intervention.

In the short term, financial incentives for reporting these data should be available to support the incorporation of PRO surveys into clinical practice. To best encourage the collection of PROs, all providers who successfully report PRO data should be guaranteed a financial incentive in the first year or two years of the program. This diverges from the approach CMS has taken with the orthopedic models; in CJR and SHFFT, providers will only see a financial benefit from their participation in the voluntary PRO option if they are already approaching the performance threshold for a higher payment level. Instead, we recommend moving the incentive for reporting PRO data outside of the quality composite score calculation to be considered separately via impact on the overall payment adjustment factor or direct financial incentive tied to sufficient PRO data submission. Though we recommend a pay-for-reporting program design in the first performance years, as noted above, over time we expect CMS to move from rewarding PRO data submission to rewarding actual performance on PRO measures.

In future expansions to the EPM program, we encourage CMS to consider episodes that begin before a hospitalization. A key benefit of this earlier episode trigger is the greater ability to assess appropriateness of care and to engage in meaningful patient engagement and shared care planning. **We encourage CMS to include measures of patient engagement and shared care planning, including shared decision-making, as much as possible.** For cardiac care, we support the use of

[8] Ibid.; Cannon, C. P., Brindis, R. G., Chaitman, B. R., Cohen, D. J., Cross, J. T., Drozda, J. P., . . . Weintraub, W. S. (2013). 2013 ACCF/AHA Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Acute Coronary Syndromes and Coronary Artery Disease: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Acute Coronary Syndromes and Coronary Artery Disease Clinical Data Standards). Circulation, 127(9), 1052-1089. doi:10.1161/cir.0b013e3182831a11

patient-centered tools including the ACC Framingham and Reynolds Atherosclerosis CV Disease Risk Calculators. We strongly support inclusion of shared decision-making tools for PCI and CABG such as from the Foundation for Informed Medical Decision Making (FIMDM) and others. These tools should take into account patient expectations and outcome goals, risk tolerance, understanding of recovery process; treatment options; and consideration of stage of disease progression. We urge CMS to build the use of such shared decision-making tools into the design of any future EPM models.

Thank you again for the opportunity to comment on the expansion of this important program. Episode payment models present a significant opportunity to improve our nation's health care system through better quality, improved care coordination, lower costs, and greater transparency. If you have any questions about our comments, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at sglier@pbgh.org.

Sincerely,

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