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August 29, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-1590-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule; proposed rules.

Dear Ms. Tavenner:

The Association for Professionals in Infection Control and Epidemiology (APIC) applauds the efforts of the Centers for Medicare & Medicaid Services (CMS) in their continued effort to promote transparency and accountability to health care, and we appreciate the opportunity to provide input on the draft proposal. APIC is a nonprofit, multi-disciplinary organization representing over 14,000 infection preventionists (IPs) whose mission is to create a safer world through prevention of infection. Our comments primarily reflect the views of our members who support public reporting of quality data, approve of the efforts to engage physicians in quality improvement, and champion efforts to reduce reporting burden.

APIC has been one of the leaders in public reporting through our involvement with the National Healthcare Safety Network (NHSN). We commend the proposal to bring physician-level quality reporting measures into the public domain and are optimistic that this will have additional influence on patient safety programs nationwide. The use of data reported under the existing Physician Quality Reporting System (PQRS) will be an excellent initial step for making physician-level performance data available to the public.

As required in the Affordable Care Act, APIC supports and endorses processes to ensure that publicly reported data are statistically valid, reliable, and accurate, and include risk adjustment mechanisms. Validation and risk adjustment are of particular importance in measures related to healthcare-associated infections (HAI). We would like to comment on the use of all-cause readmission as a group-level data measure, on the use of composite measures at the disease module level, and the use of claims-based administrative data for outcome measures.

All-Cause Readmission Measure

Though we appreciate that all-cause readmission rates can monitor performance over time and across regions and populations, we are concerned that the use of this measure in quality reporting will mask true outcomes and relationships among safety measures, will not identify which parts of patient care contribute most to patient outcomes and may hide actionable items due to the bundling of measures. Although APIC supports CMS's efforts at reducing readmission rates, the cause of readmissions are multi-factorial and often outside of the control of physician practices. We encourage CMS to invest in programs that study the effect of care transitions, enhanced communication systems, and strategies to impact patient behaviors and the effects on readmission rates.

APIC Recommendation:

We request a review of the all-cause readmission measure and support the inclusion of this measure only when the data can be risk stratified to ensure that provider groups that work with the most ill or at-risk patients will not suffer discrimination and reduced reimbursement. We further encourage CMS to explain the limitations of data measures, such as all-cause readmission, when this data is publicly reported.

Composite Measures

APIC would like to express reservations about the use of composite measures in regard to HAI-related quality measures. Composite measures do not allow for risk adjustment and do not identify targeted performance improvement strategies. Analysis of publicly reported data must provide healthcare teams with specific, actionable information to direct improvement activities.

APIC Recommendation:

We suggest that in lieu of composite measures, CMS consider the proposal that permits specialty groups to report approved, vetted and scientifically sound quality measure data via Physician Compare. This will expand reporting into specialties previously not included in publicly reported data and will provide data that will identify targeted areas in need of improvement efforts.

Claims-based Administrative Data

APIC would like to note that we are opposed to the use of administrative/claims data as a single source of HAI identification. While claims data may be useful as a supplemental method to assist in finding records to be evaluated for possible HAI, it is essential that HAIs are validated by trained surveillance personnel using written standardized protocols. Because claims data do not provide precise identification of HAIs, nor do they provide information in a timely manner to provide effective treatment and prevention, they are of limited use in preventing HAIs. However, we appreciate the efforts to reduce the burden of data entry for physician groups. In the early stages of this program, the use of

some readily available data that can be correlated with clinical criteria whenever possible is a practical first step.

Physician Quality Reporting System Measures

We support the use of the PQRS measures endorsed by the National Quality Forum for this program and the efforts to align future measures with the adoption of meaningful use standards for health information technology. We support all proposed measures for 2013 and 2014.

> **APIC Recommendations:**
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> The Pneumococcal vaccine measure in the draft proposal only includes patients over 65 years. We encourage the measure to include the full scope of patients for which the Pneumococcal vaccine is recommended, which includes persons with long-term health problems, immune deficiencies, smokers and those with asthma. (see Centers for Disease Control and Prevention. General Recommendations on Immunization. MMWR 2011; 60(nor-02); 1-60.)

Review of Data

Lastly, we support the requirement for eligible professionals to have a reasonable opportunity to review their quality data prior to posting to Physician Compare and suggest that CMS include physician stakeholders as part of the rulemaking process when changes are to be made to the program. This should minimize the risk for errors of attribution or concerns with inaccurate data.

In summary, APIC commends CMS for its efforts to drive quality practices to improve patient outcomes and thank CMS for the opportunity to comment on this draft. We encourage CMS to continue to collaborate with physician groups to identify meaningful quality measures that can be shared with the public to provide a snapshot of quality practices that enhance patient safety.

Sincerely,

Michelle Farber, RN, CIC
2012 APIC President