



1400 Crystal Drive, Suite 900
Arlington, VA 22202
Phone: 202/789-1890
Fax: 202/789-1899
apicinfo@apic.org
apic.org

June 5, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1677-P: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates.

Dear Ms. Verma:

The Association for Professionals in Infection Control and Epidemiology (APIC) wishes to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to provide input into its proposed rule updating the Hospital Inpatient Prospective Payment Systems for Acute Care and Long Term Care Hospitals for FY 2018. APIC is a nonprofit, multidisciplinary organization representing over 15,000 infection preventionists whose mission is to create a safer world through prevention of infection. We are pleased that CMS continues to demonstrate its commitment to improving the quality of patient care across the healthcare continuum. We applaud CMS for emphasizing person-centered care through establishing standardized processes that facilitate communication across the spectrum of healthcare to ensure patients are safely cared for.

As APIC supported the inclusion of standardized healthcare-associated infection (HAI) measures from the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) in the Hospital Inpatient Quality Reporting (IQR), Value-Based Purchasing (VBP), and Hospital-Acquired Condition (HAC) Reduction Programs over the past years, it was our intent that true outcome improvement and infection prevention be the goal of these measures. However, it has become apparent that, in practice, this goal has deviated in many instances to become penalty avoidance rather than improved patient care. In partnership with our healthcare organizations, CMS, and our patients, we need to find the appropriate way to realign the approach to enhancing HAI reduction.

Early infection prevention and control programs were based upon healthcare organizations identifying measures appropriate to their risks and needs. This flexibility was offered in the initial CMS Merit-Based Incentive Payment System (MIPS) program.



Recommendation:

- APIC supports a flexible approach to determining appropriate HAI prevention measures, similar to that used in the MIPS program, be taken in other CMS payment programs, using the NHSN HAI measures to monitor progress.
- APIC encourages CMS to consider incentivizing patient safety projects and activities that improve patient care and decrease infection rates. A movement toward a more positive approach to patient care and HAI reduction may help return the focus from penalty avoidance back to quality improvement.

Hospital-Acquired Condition (HAC) Reduction Program

Additional Future Measures

APIC fully supports HAI reduction efforts and values patient safety as the primary objective in a patient-centered environment; however, we do not support the use of VAE as a future measure. The VAE measure has not been sufficiently evaluated to be included as an indicator for use in payment programs.

There is currently insufficient data on VAEs and their responsiveness to quality improvement initiatives that are necessary before they should be considered suitable metrics for interfacility comparisons or pay-for-performance programs. Suitable risk adjustment strategies as well as wide scale electronic capture of VAE data are also needed. As such, APIC believes that adoption of this metric for public reporting and pay-for-performance calculations should be delayed until the measure can be validated and until more is known about what portion of VAE is preventable.

Recommendation: APIC does not support the addition of the VAE measure as an appropriate indicator for use in payment domains at this time. The measure should not be considered for inclusion in payment programs until it is more fully understood.

Recommendation: APIC does not support adding additional measures at this time.

- Adding more HAI measures to the current portfolio for payment consideration could serve to dilute the focus on improvement efforts for the current HAI measures.
- When additional mandatory measures are added, facilities are not able to prioritize the infection-related events, based on their own risks assessments, that are most relevant to the population served and services provided in their facilities.

Disability and Medical Complexity for NHSN measures in Domain 2

APIC supports the inclusion of disability and medical complexity for CDC NHSN measures. The CDC measures do not currently capture or adequately adjust for these factors related to specific patient sub-populations. We encourage CMS to work with CDC on gathering additional data via NHSN for further evaluation and future inclusion as part of improved risk adjustment of HAI specific measures.

Recommendation: APIC supports the inclusion of patient disability and medical complexity factors in the CDC NHSN measures in Domain 2. We recognize the need to have accurate risk adjustment factors applied to the evaluation of HAI reduction measures, as well as being able to trend the risks associated with infections for use in prevention strategies.



Hospital Readmissions Reduction Program

APIC is concerned about the difference in ICD-9 versus ICD-10 changes within the years cited for this 3-year timeframe especially in regard to surgical site infections. We have further concerns about the use of claims-based information as an identifier of infection. There is a lack of consistency in documentation in the medical record and this can lead to a lack of reliability in claims-based information. While claims set monetary parameters around the medical procedures performed, they are frequently unable to capture the symptomology which prompted the claim. Accurate identification of HAIs requires identification of some very specific symptoms.

Accounting for Social Risk Factors in all programs

APIC supports the view that social risk factors, such as income, education, race and ethnicity, employment, disability, community resources, and social support are important determinants of health, which impact health outcomes, including HAIs.^{1,2} APIC also supports the goals of CMS to reduce health disparities, ensure that quality of care is furnished as equitable as possible, and that beneficiaries have adequate access to excellent care. These goals will only be achievable through the collection of data in order to understand disparities and the impacts disparities have on healthcare delivery.³ APIC appreciates the ability to provide input on what social risk factors should be included and how the data should be collected. At the same time, we are concerned some facilities, particularly those without a complete electronic medical record, may not be able to efficiently gather the data needed to satisfy this reporting.

Basic demographic data, such as race, ethnicity, employment status, and disability, would be relatively easy to collect because these questions are standard to basic data collection upon presentation to a healthcare facility.

Facilities may be able to collect data relating to community resources and social support if a facility has case management resources, but CMS would need to succinctly define these data in order to understand what CMS hopes to know about these two categories.

While some institutions may collect data like income and education, many facilities do not capture these data. Facilities would need additional resources to begin collecting this information. CMS should provide clear reasoning behind the need for this information since patients may perceive answers to these questions, namely income, could adversely impact their quality of healthcare.

APIC cautions CMS to be thoughtful in how these measures are applied and encourages CMS to standardize the method and risk factors across all measures and payment programs to the degree possible. We are concerned that providing financial incentives for achievement of low readmission rates for patients with social risk factors could result in the unintended consequence of facilities not delivering needed care to patients in the face of financial incentives. Patient safety and patient-centered care should be the cornerstone of all healthcare delivery. Creating the opportunity for different standards of care could undermine patient safety elements in the provision of care.



Recommendations:

- APIC supports the collection of social risk factors to ensure quality care is equitable. We recommend data collection begin with elements relatively standard to patient admission questions across the United States, including race, ethnicity, employment status, geographical area, and disability.
- APIC recommends additional data elements be proposed within a timeline that allows facilities to develop resources around data element collection.
- APIC encourages CMS to utilize knowledge gleaned from the two-year National Quality Forum (NQF) trial and consultation with the CDC, schools of public health, and other nonprofits focused on health equity to gather additional data, provide appropriate metrics, risk models, and risk adjustment strategies.
- APIC cautions CMS on its application of these metrics in regard to the unintended consequences of misapplication of these risk factors on measures and payment programs as it relates to further disadvantaging those patients who are already disadvantaged.

Aligning Extraordinary Circumstance Exception Policies (ECE) for all programs

APIC agrees with the need to standardize the ECE processes across all CMS payment programs through (1) Allowing the affected facility to submit a form signed by the facility’s CEO or designated personnel; (2) clarifying that CMS will strive to provide a formal response notifying the facility of its decision within 90 days of receipt of the facility’s request; (3) allowing CMS to have the authority to grant ECEs due to CMS data system issues which affect data submission; and (4) standardizing the timeframe for ECE form submission to 90 days for all programs.

Value-Based Purchasing Program

Removal of PSI 90 measure beginning in FY 2019: APIC agrees with the removal of the PSI 90 measure and suggests that the proposed adoption of the modified version of the PSI 90 in 2023 be dependent upon the successful development, completion and validation of the risk adjusted model and PSI software. We believe that the elements of the proposed modified PSI 90 are important patient safety elements, but we again raise our concern with the composite measures approach, due to the inability of a composite measure to readily identify the individual measure that is causing the composite to fall-out.

Proposed Pneumonia (PN) Payment measure for 2022 Program year: APIC agrees with the need to reduce practice variation, promote better coordinated care and focus on improved outcomes, as well as promoting cost efficiency. We do caution that not all pneumonia diagnoses are comparative and risk adjustments will need to take this into consideration. We cite the comparison of a pneumonia which develops in a patient from a long-term care facility who is on a ventilator and presents to an acute care facility for treatment, as compared to a community-acquired pneumonia case in an otherwise healthy adult. We agree with CMS’ intention to submit the risk adjustment model to NQF as part of the overall proposed PN Payment measure specification for evaluation and vetting. Pneumonia occurrence and treatment can also be impacted by geographical elements, particularly in the realm of microbiology findings. This consideration should be incorporated into the decision of looking at spending across all hospitals. APIC appreciates the issue of unintended consequences with any new approach measure, which CMS mentions in this proposal statement. Unfortunately, infection preventionists are seeing unintended consequences with the HAI measures and a deviation away from prevention and



improvement with a shift towards focusing on penalty reduction without improvement efforts. These consequences must be considered in the decision-making process.

Recommendations:

- APIC supports the removal of the PSI 90 measure, but cautions CMS on the adoption of the modified PSI 90 in 2023 until the measure and associated software have been developed and validated.
- APIC continues to have concerns regarding use of a composite measure, as it reduces the ability of the institution to identify the specific component of the composite measure to fall-out of compliance.

Long-Term Care Hospital (LTCH) Quality Reporting Program

Ventilator-associated pneumonia (VAP) is a complication of ventilator care that produces excess, avoidable resource use and treatment costs. Control of VAP is an important aspect of quality of care improvement for long-term care hospitals (LTCHs) since they provide post-acute ventilator care for many Medicare beneficiaries.

Proposed Mechanical Ventilation Process Quality Measure: Compliance with Spontaneous Breathing Trial (SBT) by Day Two of the LTCH Stay and Proposed Mechanical Ventilation Outcome Quality Measure: Ventilator Liberation Rate. APIC supports this measure. Weaning programs occurring early in the patient stay have positive outcomes associated with successful ventilator weaning for patients, which in turn reduces the risk for ventilator-associated infections and contributes to a higher quality of life for patients.

APIC also appreciates data will be collected in order to ensure weaning trials are conducted only on patients deemed appropriate, as identified by valid standardized criteria, but encourages regular and early assessment for weaning in patients requiring process data regarding the percentage of patients admitted on invasive mechanical ventilation who were assessed for SBT readiness by day two of the LTCH stay and the percentage of patients deemed medically ready for SBT who received SBT by day two.

Recommendation: We support using the percentage of LTCH patients admitted on invasive mechanical ventilation, for whom weaning attempts are expected or anticipated according to standardized criteria, and are fully weaned by the end of the LTCH stay as an outcome measure. This allows the clinician flexibility in weaning those patients for who it is appropriate, and the data to accurately reflect that set of patients.

Posting Survey Reports and Plans of Correction

APIC supports transparency in healthcare delivery. Unfortunately, the variation in survey processes, interpretation and application of Standards and Conditions of Participation, leads to a lack of consistency in survey findings. Posting survey findings in their current state -- without considerable efforts to standardize them across accrediting organizations, geographic regions, care settings, facility types, and many other factors, as well as provide specific information to the public -- would not be beneficial to the public, and could result in harm to institutions. It could also result in delayed patient care and increased patient expenses as patients travel further to receive care from institutions based on negative perceptions of institutions based on erroneously reported survey results.



Recommendation:

- APIC advocates for positive approaches to call attention to healthcare improvement efforts and partnerships between organizations within the healthcare structure.
- APIC supports providing information to the public that is consistent, well explained, and useful to the patient in making good healthcare choices.

APIC appreciates the opportunity to comment on the proposed measures and continues to applaud CMS' commitment to improving quality and promoting patient safety. Our organization continues to support transparency in healthcare improvement efforts, and reporting of healthcare-associated infections as a means to that end. APIC stands ready to assist CMS in all efforts to reduce preventable HAIs based upon standardized validated measures and evidence-based guidelines.

Sincerely,

A handwritten signature in black ink that reads "Linda R. Greene".

Linda R. Greene, RN, MPS, CIC, FAPIC
2017 APIC President

¹ Anila Bakullari, A, Metersky, M, Wang, Y, et al. Preventing healthcare-associated infections: results and lessons learned from AHRQ's HAI program. *Infect Control Hosp Epidemiol* 2014;3(Suppl 3):S10-S16.

² Yang S, Rider BB, Baehr A, Ducoffe AR, Hu DJ. Racial and ethnic disparities in health care-associated *Clostridium difficile* infections in the United States: State of the science. *Am J Infect Control*. 2016;44(1):91-6. doi: 10.1016/j.ajic.2015.08.007. Epub 2015 Oct 9.

³ The Centers for Disease Control and Prevention. 2011 National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention Health Equity Symposium Meeting Report. Identifying Root Causes of Health Inequities: Using Data to Monitor and Improve Health. August 3, 2011.
<https://www.cdc.gov/nchstp/socialdeterminants/docs/2011-Health-Equity-Symp-Report.pdf>