DUE June 25, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS-1599-P: Proposed Changes to FY 2014 Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; and Quality Reporting Requirements for Specific Providers.

Dear Ms. Tavenner:

The thirty-five undersigned organizations represent The Leapfrog Group's board of directors, as well as our members which represent some of the leading purchaser and employer organizations. Through their affiliation with Leapfrog, these organizations and individuals are committed to improving the safety, quality, and affordability of health care through the use of performance information to inform consumer choice, payment and quality improvement. We appreciate the opportunity to submit comments to CMS on the proposed changes to the FY 2014 Medicare Inpatient Prospective Payment System (IPPS) rules. The detailed comments that follow this letter pertain to the following sections of the Notice of Proposed Rule Making (NPRM):

- Non-Payment for Preventable Hospital-Acquired Conditions (HACs), Including Infections
- Hospital-Acquired Conditions Reduction Program
- Hospital Readmissions Reduction Program
- Hospital Inpatient Quality Reporting Program (IQR)
- Hospital Value-Based Purchasing Program (HVBP)
- PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

The direction in which CMS is taking the programs listed above is promising. However, Leapfrog, our board, and our members remain concerned about the lack of clarity in addressing the significant gap in the public reporting of hospital-acquired conditions, the frequency in which some of the measure sets are refreshed on the Hospital Compare website, and the lack of measures that focus on common and serious medical errors such as medication errors. In addition, we remain concerned about the lack of information available to the citizens of Maryland and the U.S. Territories due to certain rules, and to patients that depend on critical access hospitals for their care. While there are many elements of this proposed rule which we strongly support, there are areas – particularly related to applicable hospitals, healthcare-acquired conditions, and public reporting – where we believe that CMS could move farther, faster, in order to push all sectors of the health care system to meet these goals more quickly and to ensure that consumers and purchasers have the best possible information before choosing a hospital.

Providing thoughtful and useful comments on the proposed rules for the various IPPS programs is becoming more and more of a challenge, due to the fact that the issues that concern us are not

addressed adequately by the quality measurement enterprise. While we believe that it is the needs of the patient – and not the measures themselves – that should drive programs and policies, we are faced with measure gaps that impede these programs from achieving their goals. Thus, in addition to our comments on the measures and methodologies that CMS is proposing, we include in our comments our thoughts on what measures we need developed in order to assess whether truly patient-centered care is being delivered.

Finally, we continue our push for the alignment between public sector (both federal- and state-levels) and private sector purchasers' value-based efforts, and hope that CMS will need to pursue opportunities to work with private purchasers and the states. We need all purchasers to work together to send a strong signal to the market about the importance of using aligned priorities to achieve common goals. This will ultimately enable providers to focus on improvement, rather than on fulfilling multiple, disparate measurement requests. We look forward to working with CMS and other partners as we seek alignment on these and related programs.

Overall, we applaud the various proposals put forward for the programs listed above. Our comments focus broadly on the following:

- **We support CMS' drive toward pay-for-reporting and pay-for-performance measures address the priorities of the National Quality Strategy's (NQS) three-part aim.** In this proposed rule, CMS has attempted to identify measures relevant to several of the NQS domains, such as patient safety, care coordination, and efficiency and cost reduction. However, we are concerned that consumers and purchasers are losing critical information on certain hospital-acquired conditions that will not be replaced with the implementation of the proposed HAC Reduction Program.

- **We encourage the addition of measures that will improve patient safety and align with other public and private sector efforts.** We welcome the proposed addition to the IQR of five measures targeting hospital readmissions, mortality, and cost, as well as the addition of measures that address high-volume patient safety issues to the Hospital Value-Based Purchasing (HVBP) Program. Moving forward, we recommend consistent prioritization of the highest volume patient safety concerns. For instance, rather than just considering the inclusion of MRSA Bacteremia and Clostridiium difficile infection rates for future inclusion in the HVBP Program, we recommend the agency finalize their inclusion as quickly as possible, in order to align with existing federal reporting programs and patient safety initiatives (e.g., the Partnership for Patients and the *National Action Plan to Prevent Health Care-Associated Infections*). In addition, since medication errors are the most common error made in hospitals, it is urgent to include some measure of medication safety. If actual error rates cannot be calculated using current science, a proxy measure should be used such as safe deployment of Computerized Physician Order Entry.

- **We urge CMS to consider opportunities for inclusion of outcome measures in the IQR Program that have significance for all consumers, not just those who are covered under Medicare.** Although CMS has proposed future inclusion of electronically-based measures for targeting populations outside of Medicare, such as measures of cesarean section and breast feeding, consumers need those measures sooner rather than later. In addition, delaying these measures

is counterproductive to efforts among private sector purchasers and payers to improve care and reduce costs in the short-term. We urge CMS to consider the quick adoption of these measures, particularly measures that will be implemented in other programs (e.g., Meaningful Use Stage 2) in the next few years.

- **We support CMS' efforts to implement the Hospital-Acquired Conditions (HACs) Reduction Program to increase awareness and accountability for HACs.** However, we urge CMS to speed up the timeline for including important measures (noted above) like MRSA and c-diff outcomes. We also suggest an alternative to the two approaches being considered for which measures should populate Domain 1.

- **Wherever possible, CMS should collect and report data on *Hospital Compare* for as many hospitals as possible, for as many important measures as possible, and in a timelier manner.** Having data that can be identified by these variables is a critical tool for identifying, and ultimately addressing and reducing, disparities in care. We urge CMS to include hospitals in Maryland and the U.S. Territories, critical access hospitals. CMS should report all data including numerators and denominators used to determine values, and Hospital Compare should include public reporting on all measures used in all CMS programs including the HAC reduction program. Additionally, hospitals should be required to report on the individual facility level, not at the systems level, for both public reporting and payment purposes. With the increasing movement towards hospital consolidation, it is critical that purchasers and consumers have a mechanism for identifying individual hospital performance, not a composite of multiple facilities within one hospital system. Even within systems, research has proven that variation among hospitals is significant, and we believe that patients have a right to know about the performance of the specific hospital where they will be receiving care.

On behalf of the individuals, purchasers, and their beneficiaries 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 The Leapfrog Group's President and Chief Executive Officer, Leah Binder, or the Leapfrog Group's Senior Director of Hospital Ratings, Missy Danforth.

Sincerely,

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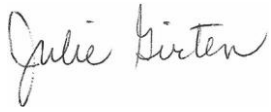

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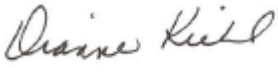

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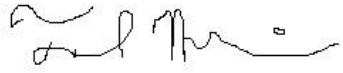

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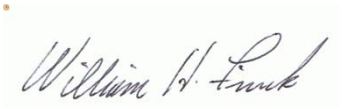

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ADDENDUM: DETAILED COMMENTS ON IPPS NOTICE OF PROPOSED RULEMAKING, FY 2014

II. F. Preventable Hospital-Acquired Conditions (HACs), Including Infections

The HAC non-payment program, established through the Deficit Reduction Act of 2005, gives CMS the authority to deny payment to a hospital for a condition that was acquired during a hospitalization, or in other words, not "present on arrival" when a patient entered a hospital for any reason. As of the FY 2013 IPPS Final Rule, this program includes the following 14 HACs:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
- Manifestations of Poor Glycemic Control
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
- Iatrogenic Pneumothorax with Venous Catheterization
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

These HACs meet the criteria of being high cost, high volume, or both, and are assigned to a higher paying MS-Diagnosis Resource Group (DRG) when present as a secondary diagnosis. Given the removal of the original eight HAC rates from the IQR (see our comments below), we are pleased that these HACs will continue to be included in the non-payment program. However, we do ask that CMS provide a clear description of where these rates will be publicly reported (whether on *Hospital Compare* or on another HHS website), the timing of data updates, and whether these data will continue to be made publicly available after 2013. We appreciate CMS' commitment to being a strong partner in transparency efforts, yet we remain challenged when it comes to understanding the strategy for reporting HACs. In particular, Leapfrog is concerned with the gap in reporting the old HAC measures and when the new HAC Reduction Program measures will be publicly reported. As these measures represent some of the most important patient safety areas, not having this information available to the public seems like a step backwards in the agencies efforts in increase transparency.

Finally, we continue to recommend that CMS expand the non-payment program to include additional surgical site infections (SSIs) for three procedures: cesarean section surgery, total hip replacement, and total knee replacement. These procedures are both high volume and high cost. Including SSIs for cesarean section would provide an appropriate partner measure to the proposed C-section rate measure being considered for the IQR program. Similarly, CMS recognizes the risk to patients during hip and knee surgeries, as reflected by the DVT/PE HAC in the list above, and by the proposed inclusion of the measure of unplanned readmission for total hip and total knee surgeries in the hospital readmission reduction program. Overall, the addition of these SSIs to this program would not only benefit

consumers, but also establish strong groups of measures for maternity/perinatal care, and for orthopedic care.

XX.X. HAC Reduction Program

We appreciate the opportunity to comment on the inaugural round of rulemaking for this new program, and believe that it will have a significant effect on overall patient safety and outcomes. While CMS proposes a number of strong measures to kick off this initiative, we believe that if the goal is to push hospitals to create a safe environment for all patients, the program must be expanded to include as many HAC measures as are currently available and meaningful to consumers, and as many hospitals as possible in the program.

First, the proposed rule lays out a definition of applicable hospitals and applicable time period. In regards to applicable hospitals, Leapfrog urges CMS to redefine applicable hospitals to include Maryland and the U.S. Territories. Citizens of Maryland and the U.S. Territories deserve the same protections as those through the rest of the country. In addition, we urge CMS to consider opportunities that would allow critical access hospitals to report on their performance on these HAC measures, and have that information included on the Hospital Compare website.

Next, the proposed rule lays out two sets, or domains, of measures for consideration in developing the scoring methodology. Domain 1 includes AHRQ Patient Safety Indicator measures and Domain 2 includes CDC measures that rely on data submitted through the National Healthcare Safety Network (NHSN). CMS asks for comments on whether Domain 1 should include ***either*** six unique PSIs, ***or*** the composite measure PSI-90: Patient Safety for Selected Indicators (See Table 1 below).

Table 1: Domain 1 of AHRQ Patient Safety Indicators

Approach A: Use Individual PSIs	Approach B: Use one HAC Composite Measure
PSI-3: Pressure Ulcer Rate PSI-5: Foreign Object Left in Body PSI-6: Iatrogenic Pneumothorax Rate PSI-10: Postoperative Physiologic and Metabolic Derangement Rate PSI-12: Postoperative PE/DVT Rate PSI-15: Accidental Puncture and Laceration Rate	*PSI-90 Includes the following measures rolled up into one composite:* PSI-3: Pressure Ulcer Rate PSI-6: Iatrogenic Pneumothorax Rate PSI-7: Central Line Blood Stream Infection Rate PSI-8: Postoperative Hip Fracture Rate PSI-12: Postoperative PE/DVT Rate PSI-13: Postoperative Sepsis Rate PSI-14: Wound Dehiscence Rate PSI-15: Accidental Puncture and Laceration Rate

Rather than Approach A or B, we propose a third approach, which is to include in within Domain 1 those PSIs listed in Approach A, but also PSI-4, PSI-8, PSI-13, and PSI-14. PSI-4 has already been implemented in the Inpatient Quality Reporting Program (IQR) so we do not understand why it's not also included in the HAC Reduction Program. In addition, we strong recommend that CMS consider re-instating the two HAC measures regarding air embolism and injuries and falls as there are not available PSIs that address these two critical patient safety areas. These two additional HAC measures could be included in Domain 1.

As it relates to the public reporting of these PSI data, Leapfrog recommends that the rates of the individual PSIs are made available, along with numerators and denominators. Making numerators and dominators available would allow Leapfrog and other researcher to do some important reliability testing that is presently not possible. If CMS decides to take the alternative approach to Domain 1, and use the composite PSI-90, Leapfrog still recommends the addition of PSI-4, and would also recommend that the individual PSIs within the composite be reported out individually, and not just the composite data as a whole. While the composite may be useful for some consumers, we believe it is critical that the results of the individual components be made transparent as well.

We strongly support the inclusion of CAUTI and CLABSI rates in Domain 2. However, we ask for explanation as to why these measures only going to be applied to the ICU population when they have been re-specified by the measure developer to apply broadly across the inpatient setting. Central Line-Associated Blood Stream Infections and Catheter-Associated Urinary Tract Infection measures are extremely important to identifying patient safety gaps, and they occur across inpatient departments. We urge CMS to broaden the scope of the population for whom these measures will apply and be reported on in *Hospital Compare*. In addition, we urge CMS to include measures of MRSA and Clostidium Difficile rates in this domain as well. These are arguably the most critical HACs affecting patients today, and it makes no sense for these to not be included in this reduction program. They are NQF-endorsed measures, and have been finalized for inclusion in the IQR.

In addition to the two Domains outlined in the proposed rule, we urge CMS to consider a third Domain, made up of two additional important measures: 1) *Procedure-Specific Surgical Site Infections (*NQF #0753), and 2) a measure of medication reconciliation or a proxy measure for medication error prevention such as Leapfrog's CPOE measure which includes indicates both implementation level and efficacy of the system in alerting prescribers to common medication errors. Surgical Site infections are a high volume HAC and should be included in this program. Medication errors are also a significant patient safety event and should be included here.

On the subject of public reporting of Domain 2, we know that the measures have been specified to calculate a *Standardized Infection Ratio* (SIR) rather than an actual infection rate. However, we know that CMS has the data to calculate straightforward rates of these HAIs, and thus we urge the agency when it comes to publicly reporting these data, to provide both the rate as well as the SIR. The SIR is certainly useful to hospitals for their quality improvement activities, given that it shows progress over time following a baseline period. However, consumers will find that information less useful than they would the rate of occurrence, which indicates a consumer's risk of contracting a HAC in their local institution. We also believe the numerators and denominators used to calculate the rates should be publicly reported.

Finally, we request clarification on the time frames for updating these data on *Hospital Compare.* The proposed rule notes that CMS will use two-year periods for collecting the HAC data. If this leads to a two-year lag time in data updates, we fear that the goal of making HAC data transparent and usable by the consumer will not be achieved. We strongly suggest that the HAC data be updated quarterly, with as short a lag time as possible.

VII. A. Hospital Inpatient Quality Reporting Program (IQR)

Measures Proposed for Removal

We support CMS' proposal to remove the following measures from the IQR program:

- PN-3b: Blood Culture Performed in the Emergency Department Prior to First Antibiotic Received in the Hospital
- HF-1: Discharge Instructions Measure
- HF–3: ACEI or ARB for LVSD
- IMM-1: Immunization for Pneumonia Measure (updated ACIP guidelines)
- AMI–2: Aspirin prescribed at discharge
- AMI–10: Statin prescribed at discharge
- SCIP-Inf–10: Surgery Patients with perioperative temperature management
- Structural measure: Systematic Clinical Database Registry for Stroke Care Measure

We are not opposed to the removal of these process and structural measures which we believe are not useful indicators of whether quality care is being delivered. However, we do not support the removal of the HAC air embolism or injuries/falls measures from the IQR program and would urge CMS to reinstate these measures as there are not replacements slated for the new HAC Reduction Program.

New Measures for FY 2016 –

We strongly support the following measures proposed for addition to the IQR for FY 2016:

- 30-Day All-Cause Risk-Standardized Readmission Rate Following COPD Hospitalization
- 30-Day All-Cause Risk Standardized Mortality Rate Following COPD Hospitalization

We believe that adding these Chronic Obstructive Pulmonary Disease (COPD) outcome measures to IQR, and subsequently reporting the data on *Hospital Compare,* will be very meaningful and useful to consumers and purchasers. In particular, we would urge CMS to report these rates by gender, given that COPD mortality rates for women have remained consistently high between 1999 and 2010, according to data from the CDC, whereas the mortality rates for males have dropped in that same period.

We do not support the addition of the 30-Day All-Cause Risk Standardized Readmission or Mortality rate measures following acute ischemic stroke. These measures were the subject of significant concern when reviewed by a multi-stakeholder steering committee at the National Quality Forum, and we share many of the concerns posed by that committee. We agree, however, that having data on stroke outcomes is critically important, and thus suggest that CMS include NQF Measure # 0467: Acute Stroke Mortality Rate (AHRQ IQI 17). This measure received endorsement from NQF in November, 2012, and could provide important information to consumers and purchasers.

Finally, we strongly support rapid implementation of the following measures:

- Severe Sepsis and Septic Shock Management Bundle
- PC-02 Cesarean Section
- Healthy Term Newborn

In the proposed rule, CMS notes that it is eager to implement the above measures when the data can be transferred via an Electronic Health Record (EHR). While we too are eager for e-Measures in these

areas, we believe that these measures are important to implement as soon as possible for their usefulness and meaningfulness to consumers, regardless of whether they are e-specified or not.

Future IQR Measures and Topics

Over recent years, CMS has moved this program forward in ways that will lead to significant improvements in quality, as evidenced by the implementation of measures related to patient safety, care coordination, care transitions, and elective deliveries. Overall, the progression from the early portfolio of IQR measures that were mainly process-oriented, to a more outcomes- and patient safety-based set of measures that will make *Hospital Compare* a more useful site for consumers and purchasers has been remarkable**.** We ask CMS to consider the following measures in IQR which 1) reflect high volume conditions and/or procedures; 2) further the goals of the three-part aim; and 3) promote alignment between the IQR and other HHS programs, including Meaningful Use, Hospital Value-Based Purchasing, and the Partnership for Patients:

- *Medication safety measures* (all of which are part of the core requirements for Stage 1 of Meaningful Use) of universal documentation and verification of current medications in the medical record; drug-drug interaction; and medication reconciliation

- *Surgical Outcomes Measures*, including lower-extremity bypass complications, ICU mortality and complications, elderly surgery outcomes and colorectal surgery outcomes

- *The registry-based CABG composite score* developed by the Society of Thoracic Surgeons (STS). Hospitals are likely already to be participating in cardiac surgery registries and have experience with collecting the type of data necessary for this, and other cardiac registry measures.

In addition, we recommend additional measures and measure concepts for implementation and development over the coming years. Where there are specific measures already available, such as the *Potentially Avoidable Complications,* we recommend CMS put these in the IQR pipeline and the *Hospital Compare* reporting process now to allow for rapid implementation into the Hospital Value-Based Purchasing program. We also offer recommendations in areas where there are no NQF-endorsed measures but that have been identified by the Office of the National Coordinator for HIT (ONC) as critical to improving patient-centered care and for which efforts are being made to speed development to get them into use:

- *Potentially Avoidable Complications (PAC) Measures:* Three recently NQF-endorsed measures look at the proportion of patients hospitalized with either 1) AMI; 2) stroke; or 3) pneumonia, and who experienced a potentially avoidable complication either during the hospital stay, or in the 30-day Post-Discharge Period. These are important and meaningful measures that can help to improve not only inpatient care, but also care coordination and transitions for three conditions that have been identified as targets for VBP. They are also intuitively understandable to consumers and purchasers.

- *Efficiency, Resource Use, and Appropriateness Measures*: We urge CMS to take a leadership role in the development of appropriateness of care measures. Conducting certain evidence-based processes well does not necessarily equate with high value care if those tests or procedures are not appropriate. Therefore, it is critical that we have appropriateness of care measures in the

IQR program to create a pathway to implementation in the VPB program. One strategy would be to build measure sets around the *Choosing Wisely* campaign recommendations. These recommendations have broad-based, multi-stakeholder support and target the highest volume/highest-cost tests and procedures.

- *Measures Related to Coronary Artery and Heart Disease (CAD and CHD):* We urge CMS to expand the number of conditions reflected in the program by FY 2015 to include measures related to coronary artery and coronary heart disease and to focus on measures related to medication, angioplasty, stents, and coronary artery bypass graft (CABG). Treatment of CAD and CHD provide an opportunity for identifying and addressing appropriate use of these procedures, particularly given the high volume and cost of stents, angioplasty and CABG performed, and the high rates of variability in quality and outcomes.

- *Measures of Patient-Reported Outcomes and Engagement:* We urge CMS to identify additional measures that use patient-reported data to assess experience of care, outcomes, and functional status. Toward that end, we encourage CMS to leverage the collaborative work it is already engaged in with the Office of the National Coordinator for HIT (ONC) and other federal partners in promoting development and/or pushing already-existing measures into the quality enterprise pipeline. One example is the Patient Reported Outcomes Measure Information System (PROMIS), which provides clinicians with outcomes data across an array of domains, such as symptoms, functional status, and pain, all from the patient's own reporting of experience. In addition, we urge CMS to explore ways to strengthen HCAHPS, especially in the care coordination domain as well as adverse events. This should include advancing activity currently underway at AHRQ to conduct focus groups with consumers about medical harm events for the purposes of expanding the HCAHPS tool.

- *Cross-Cutting Measures of Care for Patients with Multiple Chronic Conditions*: Measures of care coordination and transitions, resource use, and appropriateness that cut *across* conditions are critically needed to determine how well care is being provided to patients with multiple chronic conditions. We urge CMS to take a leadership role in tying payment to measures that will address the needs of the highest-cost and most vulnerable populations within our system.

VII. B. Hospital Value-Based Purchasing Program (HVBP)

The HVBP program's goal is to foster rapid improvement, by tying payment to high quality performance, and promoting a market that recognizes and rewards quality. As this program matures, we believe that it is successfully promoting improvement but that it could go further by tying an increased portion of hospitals' payment to performance. Thus, we continue to urge CMS to implement measures in this program for which 1) there are clear gaps in hospital performance; and 2) reflect the categories of care that are most meaningful to consumers and purchasers, such as, outcomes, functional status, care coordination and transitions, and patient experience. Overall, the changes outlined in the proposed rule reflect these recommendations.

We support CMS' proposal to, and rationale for, removing the following three measures from this program:

- AMI-8a: Primary PCI Received within 90 Minutes of Hospital Arrival

- PN-3b, Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
- HF-1 Discharge Instructions

Other Proposed Changes to the HVBP for FY 2016
We strongly support the addition of three critical patient safety outcome measures in the HVBP program:

- Catheter-Associated Urinary Tract Infection rate: As noted above in the discussion of "Post-Operative Urinary Catheter Removal on Post-Op Day 1 or 2," the most meaningful measure of whether patients are receiving safe, high quality care that will reduce the occurrence of healthcare-acquired conditions is to look at outcomes as opposed to processes.

- Central-Line Associated Blood Stream Infection rate: we have urged the inclusion of this measure across CMS hospital programs, and believe adding it to the HVBP will have a significant impact on patient safety outcomes.

- Surgical Site Infections for Colon and Abdominal Hysterectomy Procedures: these measures are already included in the IQR program, and we believe adding them to the HVBP program will bring additional focus to the issue of preventing hospital-acquired infections.

While we agree that measuring influenza immunization rates can be a strong factor in improving public health as well as have a significant effect on patient safety, we do not believe that this measure is appropriate for the HVBP. We feel that this program should be expanded to include only the highest-leverage measures, and we do not believe that this measure fits that definition. Instead, we urge CMS to include MRSA and Clostridium Difficile in this program as soon as statutorily possible.

Finally, we recommend two additional measures be added to the outcomes domain of the HVBP: *Complication Rate Following Elective Primary Total Hip Arthroplasty (THA)* and *Total Knee Arthroplasty (TKA)*; and *30-Day All-Cause Readmission Rate Following Elective Primary Total Hip Arthroplasty and Total Knee Arthroplasty*. These measures are important outcome measures for consumers who experience these high cost, high volume hip and knee replacement procedures. Because hip and knee replacements are often non-emergent procedures, information on outcomes will give consumers an opportunity to research the quality of care provided in their local hospitals. The addition of these measures would create a strong suite of hip and knee replacement-related measures, complimenting those in the IQR, the readmission measures being proposed for the readmission reduction program, and the HAC measures that we suggest be added to the HAC non-payment program in this area.

VII. C. PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
The Affordable Care Act's establishment of a quality reporting program for PPS-exempt Cancer Hospitals (PCHs) reflects the need for accountability and improvement of quality for consumers who require cancer care. Medicare spends more than eight billion dollars annually on inpatient cancer care (not including chemotherapy which is covered under Part B). And that does not begin to address the enormous additional non-clinical costs felt by family and other caregivers, community supports, and productivity loss.

We support the proposed addition in FY 2015 of both the Surgical Site Infection measure. CMS is, however, also proposing the inclusion of a long list of process measures which we do not support. Moving forward, we urge the agency to drive this program in the same way it is evolving the IQR, and finalize fewer process-oriented measures and more outcome measures. In particular, we recommend that CMS take a leadership role in developing measures of particular relevance to this program, such as measures of risk-adjusted, stage-specific survival curves for various types of cancer (e.g., lung, pancreas, liver, thyroid and esophagus, breast, colorectal).