AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and
CEO

June 25, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and other Value Based Proposals (CMS – 1694-P)

Dear Secretary Azar:

The American Lung Association appreciates the opportunity to submit comments on the Medicare Program's Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and other Value Based Proposals.

The American Lung Association is the oldest voluntary public health organization in the United States, representing the 33 million Americans living with lung disease, including asthma, lung cancer and COPD. Medicare is a program that is vital to many of these patients who depend on it to access their healthcare. The Lung Association is encouraged to see the department's focus on providing patients with additional transparency on cost of treatment and the addition of new lung cancer measures in 2020.

Risk-Adjusted Morbidly and Mortality for Lung Resection for Lung Cancer (NQF #1790) and Shared Decision Making Process (NQF #2962)
The proposed rule seeks public comment on the future inclusion of adding the Risk- Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer (NQF #1790). Overall the American Lung Association is supportive of including these measures, but has some concerns that need to be addressed prior to being adopted as a Medicare Inpatient Prospective Payment System (IPPS) metric.

Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer: The Society of Thoracic Surgeons (STS) has validated the risk adjusted morbidity and mortality for lung cancer resection metric as able to sort out high performing vs acceptable vs low performing centers. STS has used this modelling in their publicly reported Star Rating system for a subset of these resection patients who had lobectomy. The model assumes a reasonable surgical volume at the reporting institution. Small volume centers were not

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provided a star rating as their sample size was insufficient and too small for statistical discrimination. Of concern here is how the Centers for Medicare and Medicaid Services (CMS) would handle small volume centers, because their sample size has historically been too small for statistical discrimination.

The data used for developing the models are older and may not fit as well with current figures. Operative morbidity and mortality is extremely difficult as risk adjustment will be difficult to assess, as it is very subjective, according to stage of the cancer. The Lung Association also cautions that in a sense, risk adjustment is antithetical to the spirit of shared decision making as it will inhibit surgeons from offering high risk, high reward procedures which some patients might choose.

Shared Decision Making Process: The Lung Association is concerned with a few aspects of the shared decision for use as an informative IPPS metric. The majority of shared decision-making processes with regard to lung cancer resection occurs as an out-patient in a clinic or private office and may not be easily or even accurately attributed to a particular hospital. This has the potential to require redundant record keeping to demonstrate auditable compliance with the metric.

Additionally, there are specific concerns about the actual questions. The first two questions ask the "how much" question, then lump "a lot" and "some" into one category for quantitation. Sometimes a treatment plan is very clear and it would not be reasonable to do "a lot" of discussion about why not to do a clearly medically indicated curative-intent procedure outside the normal discussion of possible adverse outcomes. The Lung Association would urge the following questions:

1. *"How much did a doctor (or health care provider) talk with you about the reasons you might want to (HAVE INTERVENTION)—a lot, some, a little, or not at all?*
2. *How much did a doctor (or other health care provider) talk with you about reasons you might not want to (HAVE INTERVENTION)—a lot, some, a little or not at all?*"

to be rewritten to be "Were the advantages and disadvantages of the planned procedure and alternative procedures discussed to your satisfaction?", with yes/no answer.

Additionally, the description of the shared-decision making question antedates lung cancer screening, which was not included in the data to develop the measure. Lung cancer screening requires a shared decision-making discussion with a health care professional before implementation, which should be considered as this measure is rolled out.

<u>Request for Information: Requirements for Hospitals to Make Public a List of Their Standard Chargers via the Internet</u>

The proposed rule requests information on how to implement Section 2718(e) of the Public Health Service Act, which requires U.S. hospitals to make public a list of the hospitals' standard charges for items and services. The American Lung Association supports greater price transparency, but in order to empower patients to engage in their care and to make informed decision, price transparency is only a first step.

The requirements for hospitals to make public their standard charges must provide patients with meaningful information. The vast majority of patients have health insurance and will not pay the entire standard charge. Patients should receive individualized estimates of out-of-pocket costs, including co-pays, co-insurance and deductible based on their insurance plan. This individualized cost information would help patients and their families to prepare to manage their financial well-being as they seek

treatment for their illness. CMS should also publicize information regarding provider and hospital quality ratings along with the standard charges. This will help avoid patients believing that higher prices always mean greater quality. The Lung Association agrees that CMS should review hospitals' compliance with posting their standard prices and post a list online of non-compliant hospitals.

The Lung Association encourages CMS to be thoughtful in the design of price transparency tools. It is important that quality information be included with price transparency. Without this information, patients do not have all necessary data points to make an informed decision. The consequences of this could be exacerbated in low-income populations could further grow health disparities.

Thank you for the opportunity to provide comments on the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and other Value Based Proposals Rule. This rule has the potential to increase transparency, providing patients with valuable information to make decisions. Increased transparency is an important part of ensuring patients have quality and affordable healthcare.

Sincerely,

Harold P. Wimmer
National President and CEO

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services