Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

October 10, 2006

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Department of Health and Human Services
200 Independence Ave., NW
Washington, DC 20201

File Code: CMS-1506-P

RE: Hospital Outpatient and Inpatient Payment Changes

Dear Dr. McClellan:

Thank you for the opportunity to comment on the proposed changes to the Hospital Outpatient and Inpatient Prospective Payment System. We applaud your efforts to promote and foster increased transparency and we believe that Medicare should lead the way to promoting a market that recognizes and rewards high-quality, efficient, equitable, and patient-centered care. Publicly reporting hospital performance will allow: 1) consumers to make informed decisions about their health care; 2) insurers and purchasers to make value-based contracting decisions and use differential payments as incentives; and 3) providers' improvement efforts to be supported with better information. To that end, we strongly support Medicare using public reporting and "value-based purchasing" as strategies to promote better quality of care and more effective use of resources. (See the attached material underscoring the broad support for this effort across consumers, purchasers, and labor.)

What follows are specific comments on the three sections of the proposed rule (CMS-1506-P) that address hospital quality data, promoting effective use of health information technology, and the transparency of health care information.

SECTION XX: HOSPITAL QUALITY DATA

Outpatient Prospective Payment System (OPPS)
We support CMS' proposal to apply the 21 inpatient measures for heart attack, heart failure, pneumonia, and surgical care to the annual outpatient payment update. This would, in effect, reduce a hospital's outpatient payment by 2% if inpatient performance data were not reported. We also support tying additional performance measures, such as those suggested for the inpatient FY 2008 payment, to the outpatient payment update. We believe a reduction to a hospital's outpatient payments will be an incentive to spur submission of performance data for public reporting. However we recommend that CMS evaluate the effectiveness and consider increasing and/or shifting the reduction to reflect performance instead of merely reporting.

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Outpatient-Specific Measure Development
We understand that tying the reporting of inpatient measures to the outpatient payment update is an interim step as CMS works with stakeholders to develop and ultimately expand the number and type of quality and cost of care measures that are most appropriate and applicable to the hospital outpatient setting. Because of the lack of well-specified and endorsed measures that meet consumers' and purchasers' needs, the federal government should specifically support the rapid development of measures that are:

- **Reasonably Scientifically Acceptable:** Consumers and purchasers want measures to be scientifically sound and evidence based, but do not want the pursuit of perfection to delay the availability of good and useful information.
- **Feasible to Implement:** Rapid reporting necessitates measures that are constructed and specified so that the data needed are currently available or can be collected with limited reporting burden.
- **Relevant to Consumers and Purchasers:** The needs of consumers and purchasers for important and actionable information should drive the development of measures.
- **Reflect the Continuum of Care/Care Coordination from a Patient's Perspective:** Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.

We strongly urge that HHS or CMS also fund measure development in areas where gaps are identified and provide core operating support for the National Quality Forum (NQF) to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability of comparative information and the reduction of provider reporting burden. We are encouraged by the statement that fully developed, well-tested outpatient-specific measures could be implemented as early as January 1, 2009.

Reporting Cost of Care
Consumers are increasingly faced with a multitude of decisions and choices – such as estimating aggregate costs for a year based on plan or benefit design, and selecting a health plan, physician, medical group, hospital, health plan or treatment. Enabling consumers to make well-informed, value-based decisions means that the presentation of health care cost information should be linked to quality information and should be actionable. In general, the following two core principles should guide the presentation of cost information to consumers:

1. **Link Cost to Quality Information:** Whenever possible, cost information should be directly linked to quality measures (e.g., outcomes, patient experience, and compliance with evidence-based medicine). Linking cost and quality information facilitates the consumer's consideration of the total value of the choice they are making. When it is not possible to provide a direct link to quality information or when quality of care is not variable (e.g., receiving a flu shot), the presentation of costs should include contextual information and a general description of quality considerations (including that higher price does not necessarily correlate to better quality).

2. **Make Cost Information Actionable:** Information provided to consumers needs to be easy to comprehend (**Understandable**), easy to retrieve at the time a consumer needs to make a decision (**Timely and Accessible**) and useful in the context of a consumer's particular circumstance and needs (**Relevant**).

    - **Understandable**: Information should be easy to comprehend by the consumer. Health industry jargon should be avoided, and material should be tested for both the health and financial literacy skills of the targeted audience(s).

- **Timely and Accessible**: Cost information needs to be easily accessible at the time the consumer is making their decision. Effective dissemination and promotion of cost information is critical, as is ensuring that the information is available on-line without barriers and designed for ease of use.

- **Relevant:** To be actionable by a consumer, cost information should be as specific as possible to the consumer's circumstances (e.g., health status, insurance coverage and benefit design). Cost information should reflect the specific choice being made (e.g., the annual choice of health plan, provider selection, treatment choice) and account for an individual's or family's particular health coverage and health status. Information should include comparisons of providers and/or treatments based on quality and cost; information on possible alternatives; and potentially provide additional information related to contacting the provider or learning more about the condition. The information should predict likely expenses accurately and/or have a clear explanation of the reason for the range of cost variation and how a consumer's circumstances would likely cause them to fall within that range.

Planning for Implementing Value-Based Purchasing
As CMS embarks on the planning process mandated by the Deficit Reduction Act of 2005 for implementation of value-based purchasing by FY 2009, we would encourage the inclusion of all hospital services, both inpatient and outpatient. Going forward, CMS should:

- Continue to rapidly expand the number and type of measures that hospitals must report to obtain annual payment update. In the near term, this expansion serves as a good building block for comprehensive hospital payment reform in 2009.
- Ensure that the amount of payment linked to performance is substantial.
- Phase in a system that differentially pays providers based on nationally standardized measures, but ensure that the portion of money that is tied to performance increases over time in conjunction with the performance measures upon which hospitals are assessed.
- Construct incentives so that they take into account performance on high clinical quality, patient-centered, and efficient care, as recommended by the 2006 Institute of Medicine report on *Rewarding Provider Performance: Aligning Incentives in Medicare*.
- Ensure that provider incentives should be budget-neutral and, in the near-term, based on a combination of improvement and meeting thresholds.

In addition, both efficiency and equity represent large gaps in which there are few, if any, nationally standardized measures or approaches. During this planning phase, CMS has an opportunity to support national standards on relative use of resources and disparities in care.

SECTION XXI: PROMOTING EFFECTIVE USE OF HEALTH INFORMATION TECHNOLOGY (page 542)
Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care. In addition, if appropriately implemented, HIT can and should serve as the platform for the collection of information to supply future performance measurement, reporting and payment systems. To date, implementation has been exceedingly slow. The Secretary can spur HIT adoption and ensure that the data necessary for quality measures are captured, by using conditions of participation that require hospitals to implement HIT that:

- Complies with interoperability standards;
- Adequately protects privacy and confidentiality of patient data;

- Enables standardized quality, performance, and efficiency measurement as a routine by-product of their use; and
- Enables the merger of data with others in both the public and private sectors for the purpose of facilitating the production of standardized quality, performance, and efficiency information.

[NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT: www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]

Further, the Secretary should tie the annual hospital payment update to the reporting of hospitals' progress toward implementing Computerized Provider Order Entry (CPOE) as was noted in the 2005 Institute of Medicine's report *Performance Measurement: Accelerating Improvement*.

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to augment claims data with additional clinical data elements. The public reporting of quality and cost information would benefit greatly from claims data with richer detail. For example, accurately assessing provider performance would be greatly enhanced if the severity of the patient's condition could be captured from administrative claims data. Adding the following data elements to the inpatient paper and electronic claim forms would enable better quality and efficiency reporting:

- Unique physician identifier for each coded procedure;
- Referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION XXII: TRANSPARENCY OF HEALTH CARE INFORMATION (page 545)

As the Department builds upon its current transparency efforts, we would encourage the Secretary to increase both the scope and breadth of consumer-friendly cost and quality information by employing the action listed below. The critical need to directly link, wherever possible, consumers' cost information with quality information reinforces the importance of the federal government supporting the development and endorsement of a robust set of hospital (and other provider) performance measures.

Actions the federal government should take to increase the breadth and scope of performance information available to the public include:

- Make available physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better performance reporting.
- Continue to allow private-sector organizations to download provider performance information from the CMS Compare websites.
- Release the Medicare risk-adjusted DRG rates for every hospital (and rates for physicians), by region in easily accessible formats.
- Develop BOTH total costs of episodes of care AND total estimated beneficiary out-of-pocket costs for episodes of care (with estimates for beneficiaries with and without Medigap supplemental coverage).

CMS/HHS should consider using the following mechanisms to further enhance transparency of quality and cost information by:

- Establishing conditions of participation for hospitals that require posting of prices and policies regarding discounts and other payment options for uninsured patients. For insured individuals, health plans will likely be the primary vehicle for information that is specific to beneficiaries' condition or coverage, but CMS should play a central role in ensuring that the uninsured have access to information that is relevant to their circumstances. Informed consumer decision-making will require actionable tools and true transparency.
- The Administration through its various contracting mechanisms with health plans (via OPM or Medicare), should require that they provide tools for their enrollees to make informed choices, considering both quality and costs.

SECTION XXIII: FY 2008 IPPS RHQDAPU (Additional Quality Measures and Procedures for Hospital Reporting of Quality Data for the FY 2008 Inpatient Annual Payment Update)

To qualify for the FY 2007 annual payment update, hospitals will have to report 11 additional measures for heart attack, heart failure, pneumonia, and surgical care infection prevention. For the FY 2008 update, hospitals would have to report the following measures:

- HCAHPS;
- 30-day mortality rates for heart failure, heart attack and pneumonia; and
- Three surgical care infection prevention measures
  - VTE prophylaxis ordered for surgical patient
  - VTE prophylaxis within 24 hours pre/post surgery
  - Appropriate selection of antibiotics

For public reporting purposes, each of the seven domains within the HCAHPS survey will have a composite score, i.e., there will be seven composites and two overall ratings displayed on the Hospital Compare website. We support this approach as it provides consumers with valuable information that is easy to understand, however we urge CMS to retain the ability for consumers to drill down so that they can assess the hospital's performance related to a single question. We would also ask CMS to continue to allow private-sector organizations to have full access to provider performance information from the CMS Compare website and that the performance information for each question (rather than just the composite scores) on HCAHPS survey be available for download. Further, we applaud CMS' interest in determining a way to identify those hospitals that share a Medicare provider number and move toward displaying performance information by campus rather than by hospital system as it provides consumers with more actionable information about where to obtain services.

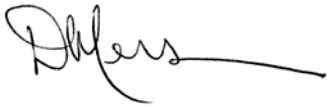
We support the expanded FY 2008 measurement set, but would also urge CMS to add the structural measures that were included in the 2005 Institute of Medicine's report *Performance Measurement: Accelerating Improvement*: (1) implementation of computerized provider order entry for prescriptions; (2) staffing of intensive care units with intensivists; and (3) evidence-based hospital referrals. All three measures are endorsed by the National Quality Forum as Safe Practices and are widely collected across the United States.

In selecting measures to adopt for FY 2008 and thereafter, CMS is proposing to add standardized measures that "have been adopted by or endorsed by a national consensus-building entity that utilizes a national consensus building process." The proposed rule goes on to identify the National Quality Forum as one such consensus building entity. In addition, the rule notes that the Hospital Quality Alliance (HQA) is another such entity. We whole-heartedly agree that the National Quality Forum is a consensus building entity and indeed adheres to the

definition of a consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 (Public Law 104-11) and Office of Management and Budget (OMB) Circular A-119. We are also very supportive of the Hospital Quality Alliance and its work to implement NQF-endorsed measures through a collaborative, public-private partnership. However, while the HQA has been instrumental in advancing hospital performance reporting via the Hospital Compare website, we do not view it as adhering to the same consensus-building process that the NQF utilizes. The roles of these two entities are distinct, though complementary. Each entity has its purpose and both are very integral to advancing the transparency of quality and cost information.

Again, thank you for the opportunity to comment. If you have any questions please contact either one of us.

Sincerely,



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