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

August 31, 2010

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

File code: **CMS-1504-P**

RE: **Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates: Comments from National Consumer, Labor, and Employer Organizations**

Dear Dr. Berwick:

The 27 undersigned organizations representing consumer, labor and employer interests appreciate the opportunity to comment on the proposed changes to the Hospital Outpatient Prospective Payment System and Fiscal Year 2012 - 2014 rates. We commend CMS' efforts to improve the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). We believe that the proposed expansion of HOP QDRP reflects a continuing commitment by CMS to advance the quality and value of care in the hospital outpatient setting and in ambulatory surgical centers. CMS' plans for HOP QDRP help support the new vision for the health care delivery system that the American Reinvestment and Recovery Act (ARRA) HITECH program (which established the meaningful use incentive program) and the Patient Protection and Affordable Care Act (ACA) set forth: a patient-centered system of care that is both HIT-enabled and uses robust measures of performance to promote transparency and value-based payment of care.

Our comments pertain to issues raised in Section XVI of the proposed rule on Reporting Quality Data for Annual Payment Update:

- **Overall, we support the measures proposed**. We are pleased that there is a strong focus on measures of overuse, efficiency, care coordination and transitions, and the process measures being proposed do have strong links to outcomes. These measures reflect the National Priorities Partnership-identified goal areas of overuse, patient safety, and care coordination and will provide meaningful information to consumers, purchasers, and providers. We do urge CMS to consider additional outcome measures that are relevant to the hospital outpatient setting, which we note in more detail later in these comments.

- **We applaud CMS for proposing implementation of Health IT structural measures.** Adding these measures to the outpatient pay-for-reporting program means they will be reported on the *Hospital Compare* website, which will provide those who receive and pay for care critical information on which hospitals are striving to establish HIT-enabled systems to improve care coordination, patient safety, and outcomes.

- **We urge CMS to implement a tool for measuring patients' experience of care in the hospital outpatient setting and make it a requirement for the annual payment update.** While the direction of the HOP QDRP is moving toward improving value and quality for all patients, there is a glaring lack of patient experience measures. As noted in the proposed rule, CMS is proposing specific care transition and patient education/counseling measures for CY 2012 and beyond. Directionally, we support these measures but in order to ensure they do not fall into the "check-the-box" category,

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there must be a patient experience survey and/or measures to evaluate the extent to which patients understand and were able to act upon the information they received.

Developing Three-Year Payment Determination Periods

Consumers, labor, and employer organizations support developing a three-year plan for HOP QDRP. We agree with CMS' contention that this will provide hospitals with the information they need to prepare their quality data collection and reporting systems for new measures. We appreciate the language in the proposed rule that having a three-year plan will not preclude CMS from proposing additional measures or making other changes to the list within the years affected by this rulemaking cycle. This reflects the fact that there may – and probably will – be significant changes to the quality measurement enterprise stemming from both the meaningful use program as well as the myriad quality-related elements laid out in ACA. It also reflects the need for CMS to make necessary changes in response to experiences with the measures that may arise and result in unintended consequences.

We suggest that in the final rule's description of the three-year payment determination period there should be some reflection of ACA and ARRA/HITECH, and acknowledgement that these laws may have an effect on the program between CY 2012 and CY 2014. For example, the Secretary of Health and Human Services is required to develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health and present that plan to Congress by January 1, 2011.

Current and Proposed Measures for HOP QDRP

The proposed rule asks for comments regarding the continued use of the current set of 11 measures. We are concerned that measure OP-6, "Timing of Antibiotic Prophylaxis" may foster the overuse of antibiotics – which is supported by anecdotal evidence – with implications for both health care costs and the public health and welfare. We urge CMS to reconsider the inclusion of this measure for the HOP QDRP and reassess the evidence-base for its use. Until we are able to efficiently collect data, for all measures we also encourage CMS to weigh the potential to improve quality with the burden of data collection to ensure reporting is well worth the investment.

<u>CY 2012</u>
We support 3 of the 6 measures proposed for CY 2012:

- Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified HER System as Discrete Searchable Data
- Pre-operative Evaluation for Low Risk Non-Cardiac Surgery Risk Assessment
- Troponin Results for ED AMI Patients or Chest Pain Patients Received Within 60 Minutes of Arrival

All three of these measures relate to issues that are meaningful to consumers and purchasers and are important for both public reporting and payment policy. The use of HIT in the hospital outpatient setting to transfer laboratory data will improve patient safety and health outcomes, and potentially reduce human error and redundancy of laboratory orders, all of which will have an impact on costs. The volume of cardiac imaging that is done as part of the pre-operative evaluation process for Medicare patients who are undergoing low-risk, *non-cardiac* surgery is a significant cost and patient safety concern. This measure will have the potential to drive down the overuse of cardiac imaging procedures in cases when they are not necessary according to the evidence-base. Finally, we support the troponin results measure, which will help improve the efficiency with which patients who present with possible acute myocardial infarction (AMI) or chest pain are diagnosed and provided with the proper treatment. This measure provides symmetry to the HIT structural lab results measure, both of which reflect the need to decrease laboratory turnaround times, increase efficiency in how information is transferred and used, and ultimately decrease the time a patient spends in the emergency department.

CY 2013

We support all seven measures proposed for implementation in CY 2013:

- Tracking Clinical Results Between Visits
- Median Time from ED Arrival to ED Departure for Discharged ED Patients
- Door to Diagnostic Evaluation by a Qualified Medical Professional
- Patient Left Before Being Seen (ED)
- Transition Record with Specified Elements Received by Discharged Patients
- Median Time to Pain Management for Long Bone Fracture (ED)
- Head CT Scan Results Interpreted Within 45 Minutes of Arrival for Acute Ischemic Stroke or Hemorrhagic Stroke Patients

The HIT structural measure "Tracking Clinical Results Between Visits" has our support for the same reasons expressed in the above section on CY 2012. It is of critical importance to encourage hospitals to develop HIT-enabled delivery systems that will allow for tracking of clinical results and have that data made publicly available.

We support the range of Emergency Department (ED) throughput measures. Lack of efficient throughput in the ED leads to negative health and cost consequences, including poorer quality care and health outcomes, longer-than-appropriate ED stays, risks to patient safety, patients leaving without being seen, and reduction in access to the ED for additional patients.

We are pleased to see the HOP QDRP program potentially including a care transition measure, "Transition Record with Specified Elements Received by Discharged Patients," and we believe that the hospital outpatient department is ripe for care transition improvement. However, in addition to supporting implementation of this measure, we urge CMS to develop a partner measure that examines whether a patient and/or family caregiver understands the information provided in the transition record and can follow the protocols outlined. While having a transition plan is the first step toward addressing care transitions, in order to truly improve outcomes and reduce readmissions and mortality, it is important that patients are provided with the necessary supports for successful care transitions and are not simply handed a piece of paper.

Finally, we support two ambulatory care measures, which are pending NQF endorsement, that are strongly related to patient safety: "Median Time to Pain Management for Long Bone Fracture" and "Head CT Scan Results for Stroke Patients Within 45 Minutes of Arrival." Long bone fracture and acute ischemic and/or hemorrhagic stroke are high-volume occurrences in the hospital outpatient setting. Pain management for long bone fracture is not consistent, and without it, patients not only suffer unnecessarily, but may experience complications including shock. In regard to the stroke measure, the timing of Head CT scan results (including not just receiving the results but interpreting them as well) is crucial to helping providers make the decision about whether or not to administer tissue plasminogen activator (t-PA), a stroke therapy which is most productive if given to the patient within 3 hours of a stroke.

CY 2014

There are five discrete diabetes process measures proposed for CY 2014, all of which were initially specified for physician level reporting and are included in the Physician Quality Reporting Initiative (PQRI) program. We do see the value in applying these measures to the hospital outpatient setting given the high – and growing – percentage of diabetes patients who are receiving care through hospital outpatient clinics and academic medical centers. For these patients, having information on the quality of care provided at the hospital level – while not as useful as having individual physician-level reporting – would be meaningful and allow for more informed decision-making.

However, we feel these would be more useful to consumers if reported as a single composite measure of quality of diabetes care, with the ability for providers and purchasers to drill down into the data to make decisions regarding benefits and quality improvement. We also suggest that CMS clarify how these measures would be specified for the hospital outpatient setting, given that they are currently specified to be calculated using physician CPT-II code data, but in the proposed rule they are characterized as chart-abstracted data measures. Given that a significant percentage of primary care services are provided in the hospital outpatient clinic setting, we presume there will be future proposed rules in which CMS will seek to apply PQRI or other physician-specified measures to the hospital outpatient setting. Directionally, this is appropriate, and addresses our continued calls for harmonization across settings and the need for the silos of care to be broken down. On a practical level, however, we would like to have more detail on CMS' plan for achieving this implementation challenge by clarifying how the translation from PQRI to HOP QDRP will occur.

Finally, we support the implementation of the imaging efficiency measure "Exposure Time Reported for Procedures Using Fluoroscopy," which will require hospitals to note how much time a patient is exposed to radiation. In a future in which all patients records are electronically based, this measure will allow patients and their providers to track how much cumulative time they are exposed to fluoroscopy, which will have critical implications for patient safety.

Proposed Future Measures

In general, we commend CMS for citing a focus on outcomes, efficiency and patient experience as criteria for selecting proposed measures for HOP QDRP. As reflective of our comments earlier in this letter, we do believe that the emergency department, HIT structural, and imaging measures do fall into some of these categories and additionally meet patient safety concerns. However, CMS has missed the opportunity in this proposed rule to offer a strong set of outcome, patient experience, and care transition measures for the next three-year payment determination period. Three measures that we urge CMS to consider for the next three-year payment determination period include:

- Patient experience survey: Currently hospitals are required to report their HCAHPS data to CMS in order to receive their full inpatient payment update. We strongly urge CMS to add a patient experience survey to the outpatient program. While there is not a CAHPS version specifically tailored to the outpatient setting, we suggest that CMS look into ways that either HCAHPS or the Clinician/Group CAHPS survey could be specified appropriately for the outpatient arena. This is a critical gap in the program that must be filled.

- Emergency Department AMI mortality: An ED AMI mortality measure is already being collected and publicly reported in California. This type of measure would be appropriate, particularly in light of the other ED AMI measures being considered for implementation.

- Emergency Department non-mortality outcome measures: There are several NQF-endorsed ED outcome measures that we have suggested for implementation in the past. These include the Severe Sepsis and Septic Shock Management Bundle, and Confirmation of Endotracheal Tube Placement.

We appreciate the opportunity to comment on the wealth of measures and measure topics that CMS put forward for future consideration.

Of the 14 heart failure measures, 7 of them are discrete process measures that are currently being reported in the inpatient pay-for-reporting program (RHQDAPU). We believe the hospital pay-for-reporting programs – both inpatient and outpatient – should make a deliberate move away from process measures, except where the process is directly and closely linked to outcomes. However, we do appreciate the need for harmonization between the two hospital settings, and the need for quality improvement in the outpatient environment. Thus, we support the addition of these measures, but urge CMS to report the data as a Heart Failure Quality of Care composite, in order to make the information more useful and meaningful to consumers.

The same holds for the heart failure measures related to symptom management, symptom and activity assessment, patient education, and end-of-life-plan. These are extremely important areas that we would like to see included in the HOP QDRP (and then harmonized to RHQDAPU); in terms of public reporting, however, we suggest that CMS conduct focus group testing to determine whether they would be most useful to consumers if reported as a composite. Additionally, it is important to ensure the data collected via these measures are truly meaningful and accurate. Unfortunately, these are the types of activities for which it is all too easy to just "check the box" that management, education, and planning was complete, without any true sense of whether a patient benefitted from these activities. Thus we again urge CMS to develop companion measures that evaluate patients experiences with care to get at whether patients truly felt their symptoms were being managed, they received the education they needed, and were provided support and assistance in developing an end-of-life plan.

We support the last two heart failure measures "overuse of echocardiography" and "post-discharge appointment for heart failure patients." In the past we have called upon CMS to implement more cardiac imaging overuse measures, and we have expressed in this letter the need for additional care transition measures.

As for the other proposed future measures, we support all except for "Needle Biopsy to Establish Diagnosis of Cancer Preceding Surgical Excision/Resection." This measure quantifies something that should be a standard of practice, and we do not consider it a quality measure that should relate to payment policy. We are also not in support of "Appropriate Surgical Site Hair Removal." While it is currently implemented in the RHQDAPU program and applying it to HOP QDRP would satisfy our call for harmonization of measures across settings, we do not feel this measure is terribly meaningful for consumers and purchasers. It nominally addresses a patient safety concern, but in reality the compliance with this measure is very high in RHQDAPU. We feel that there are other, more important measures that could be added to the HOP QDRP program that would provide more useful information for stakeholders and be more appropriate for payment determination.

Proposed Topics for Future Measure Development
Of the list of measurement topics proposed for future development and consideration in the HOP QDRP, we would highlight the following as being the highest priority:

- Chemotherapy
- Post-discharge follow-up
- Post-discharge ED visit within 72 hours
- Safe Surgery Checklist
- Immunization Refusal Rate (assuming this pertains to hospital staff refusal)

The measurement topic areas listed above are not only appropriate to the hospital outpatient setting, but also critically needed. All of these topics address clinical and/or cross-cutting areas that would affect a high volume of patients and have the potential to improve outcomes and reduce costs.

Reporting of Ambulatory Surgery Center Quality Data

We urge CMS to include ASCs in the HOP QDRP in CY 2012 and beyond. According to a survey conducted by the National Association of Health Data Organizations (NAHDO), more than 35 states are currently collecting and using ASC data, and these institutions are becoming more familiar with the electronic submission process. The percentage of outpatient services being provided in ASC settings has grown significantly and will only continue to grow. This is particularly critical, in light of the language in the Affordable Care Act requiring CMS to develop a value-based purchasing program for ASCs. We do appreciate that CMS is now offering a set of potential measures for ASC quality data reporting and we look forward to seeing the plan now being formulated for creating the value-based purchasing program.

Electronic Health Records

We appreciate that CMS is actively trying to find alternatives to manual chart abstraction for the collection of quality data, particularly since several of the measures being proposed in this rule do rely on chart abstraction, which is burdensome for providers. We fully support CMS working with HIT standard-setting organizations to promote the adoption of standards for data capture to encourage the development of new measures – or e-specification of already-existing measures – that can be populated using EHR-collected data. We also support CMS working across pay-for-reporting programs to enable hospitals to use EHR data in one setting to report on measures that apply in additional settings. Harmonization of measures across settings should both drive, and receive the benefits of, an EHR-enabled data collection system.

On behalf of the millions of Americans represented by the undersigned organizations, thank you for your efforts and your responsiveness to our comments. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, David Lansky, President and Chief Executive Officer of the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,

AARP
AFL-CIO
American Hospice Foundation
Business Healthcare Group of Southeast Wisconsin
Center for Payment Reform
Childbirth Connection
Consumers CHECKBOOK
Consumers Union
Employers Coalition on Health
Employers Health Purchasing Corporation of Ohio
Florida Health Care Coalition
Health Action Council Ohio
Health Care Incentives Improvement Institute
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
Iowa Health Buyers Alliance
Mid-Atlantic Business Group on Health
Midwest Business Group on Health
National Business Coalition on Health
National Retail Federation
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Pacific Business Group on Health
PULSE of America
Service Employees International Union
The Alliance
The Leapfrog Group