

August 31, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

File Code: CMS-1414-P (Proposed Changes to the Hospital Outpatient Prospective Payment Systems and Fiscal Year 2011 Rates)

RE: Consumer, Labor and Employer Comments on Medicare Hospital Reporting and Healthcare-Associated Conditions

- Reporting Quality Data for Annual Hospital Payment Rate Updates
- Healthcare-Associated Conditions

Dear Ms. Frizzera:

The 17 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 2011 Rates. We would like to commend CMS's efforts to foster increased transparency and promote a market that recognizes and rewards quality. The health care reform debate currently taking place has put a critical focus on the need to change how Medicare and other purchasers pay health care providers. We must move payment to be increasingly based on value, rather than on volume. Continuing to refine and strengthen the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) is one way that CMS can play an important role in advancing the effort to bring quality and value into the hospital outpatient and ambulatory surgical center (ASC) arenas.

The comments that follow are based on our belief that measurement, performance feedback, public reporting, and appropriate financial incentives are central to transforming the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. Public accountability for performance and differential performance-based payment are critical incentives that can spur changes and foster a health care system that:

- Improves clinical quality by addressing problems of underuse, overuse, and misuse of services;
- Encourages patient-centered care, patient engagement, and shared decision-making;

- Encourages care coordination and supports the integration and delivery of services across providers and care settings, particularly for the frail elderly and those with chronic illness;
- Reduces adverse events and improves patient safety;
- Avoids unnecessary costs in the delivery of care;
- Stimulates investments in structural components and system-wide re-engineering of care processes, particularly through health information technology;
- Reduces disparities in health care and encourages the provision of quality care for at-risk populations in a culturally competent manner; and
- Provides meaningful performance information to consumers, providers, and others.

Our comments all pertain to issues raised in the section of the proposed rule pertaining to hospital quality data reporting, data validation, and the healthcare-acquired conditions program.

Section XVI: Reporting Quality Data for Annual Payment Update

- **CY 2011 Measures:** CMS proposes to use 11 measures for the HOP QDRP that were published in the OPSS CY 2010 final rule, and does not list any new measures proposed for inclusion in the program for CY 2011. We believe that the current set of measures can and should be supplemented with additional measures to provide a better reflection of hospital quality.

In the comment process for the CY 2010 HOP QDRP update, consumer, labor and employer groups suggested a number of areas where there are measures available that could be added to the program to improve outpatient quality of care, including:

- Emergency Department AML mortality (such as the one collected and publicly reported in California)
- Emergency Department-related non-mortality outcome measures (such as the *Severe Sepsis and Septic Shock Management Bundle* and *Confirmation of Endotracheal Tube Placement*, both of which received time-limited endorsement by the National Quality Forum.)

In terms of broad issue areas, we restate our recommendation that CMS consider measures that can be applied to the outpatient setting that address:

- Overall cardiac care
- Use and overuse of Cardiac CT
- Percutaneous Cardiac Interventions (“PCI”)
- Care transitions.

PCI and care transitions measures in particular can provide information on outpatient hospital programs’ ability to reduce inpatient admissions, avoid potentially unnecessary CABG procedures, and reduce readmissions due to poor discharge and transition experiences. These measures are available, well tested and should be implemented by CMS for the hospital outpatient setting.

CMS should also consider adding measures to the HOP QDRP that would harmonize outpatient reporting where appropriate with the inpatient RHQDAPU program. While there may be the need to refine specifications for the outpatient setting and conduct

testing in outpatient settings, inpatient measures that could be appropriate in the outpatient setting include:

- AMI-2: Aspirin prescribed at discharge
- AMI-5: Beta Blocker prescribed at discharge
- HF-1: Discharge instructions
- PN-3b: Blood culture performed before first antibiotic received in hospital

Finally, in the absence of new measures in CY 2011 beyond those adopted in last years OPPS final rule, we ask that CMS take this opportunity to foster development of measures designed to assess quality of health outcomes in the outpatient setting. This is particularly timely in light of the national debate over reform of the health care system, the gaps in measurement identified by the National Priorities Partnership, and the recent CMS roadmaps on quality measurement, resource utilization and value-based purchasing. CMS should be forward looking and seek to align its measurement, reporting and payment efforts with other public and private sector efforts seeking to foster value-based purchasing, care coordination, patient-centered care, and improving patient safety and outcomes. In particular, CMS should identify measures in the areas of resource use and efficiency; discharge planning and care coordination; and outcomes. As more and more care is being delivered in the outpatient arena, both in the hospital and Ambulatory Surgery Center (ASC) setting, CMS should use this time to consider the portfolio of measures on which hospitals have to report, and develop a plan to create a fuller set of measures upon which to assess care.

- **Proposed Measures for CY 2012:** As noted above, we are in favor of measures being added to the program that will provide information on the things that are most relevant to delivering patient-centered care: outcomes, care coordination, discharge planning, and resource use and efficiency. Essentially, none of the measures proposed for consideration for 2012 fall under these categories, although many are linked to outcomes or population health and safety. As the program matures, we support moving away from process measures and measures that reflect what should be standards of practice – such as *Needle Biopsy to Establish Diagnosis of Cancer Preceding Surgical Excision/Resection*, and *Appropriate Surgical Site Hair Removal* – and toward measures that will provide information on how well outpatient settings are doing at improving outcomes and functional status for patients, as well as ensuring that their care transitions are done appropriately. These would include measures such as rate of surgical infections in outpatient surgery centers, and rate of infection outbreaks related to contaminated scopes, syringes, and other medical equipment.
- **Reporting by Ambulatory Surgical Centers:** We urge CMS to include ASCs in the HOP QDRP in CY 2011. 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.
- **Public Display on Hospital Compare:** There are a number of concerns related to public display on which we wish to comment.

Reporting by Individual Hospitals: CMS proposes to display combined information from “related hospitals” on Hospital Compare and then indicate that the performance

measures combine results from two or more hospitals that share the same Medicare Provider Number. This type of data display is misleading and will not allow consumers and purchasers to assess and use the information, reducing the effectiveness of Hospital Compare. "Related" hospitals do deliver different performance results. CMS should require reporting at the unit of the hospital rather than the Medicare Provider number. HQA has provided CMS with strategies for adding an identifier to the Medicare Provider Number that would differentiate individual hospitals.

Choice of Measures: Earlier we commented on measures based on whether they meet the goals of value-based purchasing, quality improvement, and promoting patient-centered care. In the context of public reporting, however, we urge CMS to consider the need for measures that are methodologically specified in such a way as to allow for a range of results, rather than results that show the vast majority of hospitals being displayed as "average." CMS is a major implementer of quality measures and can use its leverage to push the quality measurement enterprise toward developing measures that will be more useful ultimately for consumers and purchasers. Without the ability to make meaningful comparisons among hospitals, the effectiveness of Hospital Compare is reduced. If almost all the hospitals fall into the "average" category, consumers will not have the tools they need to make meaningful decisions.

Data Display: In anticipation of HOP QDRP measures being reported on Hospital Compare, we urge CMS to consider data display mechanisms that will be most conducive to providing consumers and purchasers with usable, meaningful information. For example, currently the critically important readmission rate measures are displayed based on a scale of three: "better than the national rate, no different than the national rate, and worse than the national rate." Out of 4,520 participating hospitals in the U.S., 2,488 fall into the "no different than the national rate" category, and only 36 and 52 hospitals fall into the "better than" and "worse than" categories, respectively.¹ Thus, we believe CMS should develop a display mechanism that provides consumers with a more accurate sense of where the hospitals in their area fall. In addition, we urge that Hospital Compare provide access to the data in greater detail so that those who use the site can see the numbers behind the "no different than the national rate" designation, similar to what is being done by the "Stop Hospital Infections" campaign.² We understand that CMS has been working toward efforts to improve data display of mortality measures, and believe these efforts should be pursued for all measures, including those relevant to the outpatient reporting program.

- **Data Validation Processes:** CMS is proposing a mandatory reconsideration and appeals process for hospitals who want to have their payment decision reconsidered – during which period public reporting would be put on hold. We understand and support the need for effective review processes to ensure data validation, but urge that strict timelines be set so that the public has access to this information as quickly as possible. This means publishing data that has undergone the test validation process with an eye toward public reporting of the most up-to-date hospital outpatient data possible (e.g. 2nd and 3rd quarter 2009 validated data) on Hospital Compare no later than June, 2010.

¹ 1,944 hospitals did not have enough cases to be included in this reporting.

² See http://www.stophospitalinfections.org/infection_prevention for more details

Section XVII: Healthcare Associated Conditions (“HAC”)

In both the HAC listening session and in the CY 2009 OPSS Proposed Rule, CMS discussed the potential for expanding the HAC non-payment policy to the Hospital Outpatient Program (HOP) setting. The leading consumer, labor and employer organizations that have commented in these processes have generally been enthusiastic supporters of innovative payment reforms that may lead to improvements in patient safety, outcomes, and quality of care. However, in this case we feel that the reconfiguration of the HOP’s current coding and reimbursement structures – particularly with regard to Present on Admission (POA) coding – that would be required to replicate the Inpatient HAC non-payment program make this an initiative that should be implemented cautiously, and therefore, gradually. There are two major technical challenges facing the implementation of non-payment for HACs in the HOP setting: (1) lack of a system for POA coding; and (2) the fact that “present on admission” is defined by CMS to include conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery.³

We recommend that CMS begin by focusing its non-payment for HACs policy on two areas: outpatient surgery, and outpatient procedures that are correlated with potential for injury. One example of this would be endoscopy. The technical complexities involved in developing fair and consistent reimbursement in areas beyond these areas would most likely not be a cost-efficient use of limited CMS resources, and may not have the desired effect of significantly improving outcomes. At the same time, we recognize that HACs are relevant beyond the realm of surgery and certain procedures – such as death or disability due to drug events – when applied in the broader HOP environment. Including non-surgical HACs may help pave the way for payment reform that goes beyond the institution, and addresses the need for provider-specific non-payment both inside and outside the hospital setting, where appropriate.

While there are opportunities to develop HAC policies in the outpatient setting, we believe that CMS – and Medicare beneficiaries – would be better served by focusing its payment reform efforts not on the HACs in the outpatient setting but instead on other strategies for initiating payment reform in the outpatient setting that have higher potential of promoting better quality and more affordable care, such as:

- Gainsharing between institutions and physicians, coupled with strong patient protections
- Creating episode-based payments across a continuum of care
- Rewards programs
- Focusing on reducing readmissions
- Aligning non-payment for hospitals with non-payment for physicians.

Overall, we believe that both positive incentives and non-payment policies must incorporate a move away from “siloed” thinking and creating aligned reforms across settings.

As a general matter, we believe that any HAC payment policy should be expressly designed to ensure that there are no negative effects on patients’ access to the care needed for

³ Rich, Jeff, M.D., “HACs in Practice – Mediastinitis Following CABG,” CMS Listening Session on HACs,

treating the HAC. Similarly, policies must ensure that patients who may be more susceptible to HACs are not turned away based on institutions' or clinicians' fear of nonpayment.

Beyond the proposed non-payment policies for HACs, we encourage CMS to develop alternative payment mechanisms that would provide incentives for high quality care. Examples of such incentives include implementing episode-based payments that encompass care in and outside of the OPPS; and payments that recognize and reward more effective post-discharge care.

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 Disclosure Project's co-chairs, Peter V. Lee, Executive Director of National Health Policy, Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AFL-CIO
American Benefits Council
American Hospice Foundation
Childbirth Connection
Consumers Union
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
Iowa Health Buyers Alliance
Mid-Atlantic Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
New Jersey Health Care Quality Institute
New York Business Group on Health
Pacific Business Group on Health
Service Employees International Union
St. Louis Area Business Health Coalition
The Leapfrog Group