

Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.

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

File code: CMS-1613-P

RE: Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Ms. Tavenner,

The 25 undersigned organizations representing consumer, labor and employer interests appreciate the opportunity to comment on the proposed rule updating the Hospital Outpatient Prospective Payment System for CY 2015. Our comments focus on the Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) programs.

We applaud CMS' efforts to increasingly focus on measures of outcomes, efficiency, care coordination and safety that demonstrate meaningful variation in performance. Moreover, we support the implementation and refinement of these programs to increase transparency, promote alignment across federal quality initiatives and programs, and ultimately achieve the goals of the National Quality Strategy. While we are pleased to see that this year's proposed rule continues to build on past efforts, we are concerned that the progress is not substantial enough. To that end, we describe opportunities to accelerate the pace of change, including:

- Ensuring easily accessible and comparable information on outpatient and ambulatory surgical center quality to support consumer decision-making
- Aligning the OQR and ASCQR programs with public- and private-sector value-based programs

Ensuring easily accessible and comparable quality information

Outpatient surgical procedures are often high-cost and place patients at risk for potential adverse events and outcomes. Given that the majority of surgeries in the U.S. take place in the outpatient setting,ⁱ there is a need for easily accessible and comparable quality information across all outpatient surgical settings to inform consumer decisions regarding their choice of provider. Currently, information on the OQR program is available on *Hospital Compare*. We urge CMS to report results from the ASCQR program on this site as well, so that consumers who may receive care in either setting can access and compare the same quality information for both settings. Furthermore, future iterations of these public reporting programs should allow consumers to access meaningful information on out-of-pocket costs as well.

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Aligning the OQR and ASCQR programs with value-based programs

Consumer-Purchaser Alliance is extremely supportive of CMS' continued efforts to create a health care system that rewards value through the establishment of a comprehensive payment policy that includes bundled payments. We also encourage CMS to continue to play a leadership role in driving quality improvement in priority areas across all settings of care by working deliberately with private purchasers and the states.

Building on these opportunities to accelerate progress, we offer detailed comments on CMS' measure-specific proposals for the OQR and ASCQR programs below.

Topped-out OQR measures for CY 2017

CMS proposes to remove three process measures that have demonstrated little variation in performance in outpatient hospital settings:

- OP-4: Aspirin at Arrival (NQF #0286)
- OP-6: Timing of Antibiotic Prophylaxis
- OP-7: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)

We support removing these topped-out measures, recognizing that they have achieved their goal of instituting standard practices for the treatment of heart attacks and prevention of surgical infections.

Proposed new measure for OQR and ASCQR for CY 2017

CMS proposes adding one new measure to both the OQR and ASCQR programs for CY 2017 – Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy. We support the addition of this outcome measure, which addresses adverse events following colonoscopy, recognizing that colonoscopy is one of the highest-volume procedures performed in the outpatient setting.ⁱⁱ We appreciate CMS' consideration of the Measure Applications Partnership's input, and share CMS' belief that reporting this measure will improve transparency in quality information for the outpatient setting and ultimately drive improvements in patient care.

We view the inclusion of the colonoscopy measure as a good first step in the continued evolution of these programs, and encourage CMS to address a broader spectrum of high priority patient outcomes. With regards to patient outcomes specific to colonoscopies, we believe there is a need for additional meaningful outcomes that are understandable to consumers. For instance, the American Gastroenterological Association (AGA) has a process measure that evaluates the percentage of patients whose colonoscopy procedure report documents whether the polyp(s) were totally removed.ⁱⁱⁱ While we do not believe that this measure is meaningful to consumers and purchasers in its current form, there is an opportunity for CMS to work with AGA and others to develop a similar outcome measure that goes beyond mere documentation, and allows patients to evaluate whether his/her colonoscopy was successful, i.e., it found and safely and completely removed all existing polyps. Furthermore, we believe the most meaningful outcome following colonoscopy would address whether a patient with malignant polyps remains cancer free. This type of evaluation represents a current gap in performance measures, which we discuss in more detail in the section titled "Measure Topics for Future Consideration."

Proposed Measure Exclusion for CY 2016

CMS proposes to exclude OP–31 Cataracts Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery (NQF #1536) from the 2016 payment determination and make it a voluntary measure for CY 2017 and thereafter.

Consumer-Purchaser Alliance is disappointed that this measure’s implementation has allowed for an inconsistent approach to visual acuity evaluation, which has caused CMS and some stakeholders to question its merit. However, we strongly support patient-reported outcome measures as an extremely patient-centered approach to quality improvement. We urge CMS to promote a standardized approach to this measure’s use that consistently leverages evidence-based instruments for evaluating visual acuity, and believe that in doing so, it will produce meaningful results for consumers, encourage care coordination across outpatient facilities, and promote quality improvement. In the meantime, we ask CMS to identify additional measures that address patient outcomes for the high-volume of cataract procedures performed in the outpatient setting that can be useful for guiding consumer decision-making and quality improvement. Specifically, we ask that CMS revisit the inclusion of Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures (NQF# 0564) as a required measure for both the outpatient and ambulatory surgical center settings. This measure was originally proposed by CMS but never finalized in the CY 2014 OPSS rulemaking process due to stakeholder concerns about the low prevalence of complications following cataract surgery. While we recognize that complications following cataract surgery are relatively uncommon, we do not believe that makes them acceptable occurrences, nor does it decrease the unacceptable burden on patients who may experience loss of vision, retinal detachment, or other adverse outcomes following this procedure. We also appreciate concerns raised by other stakeholders about the effort of data collection for this measure, which requires facilities to track subsequent surgical procedures due to complications that may occur at a different facility. However, we strongly believe this is an opportunity to promote improved care coordination and track progress on important patient outcomes across episodes of care. In addition to measuring post-operative complications, we also urge CMS to consider the inclusion of Better Visual Acuity Within 90 Days Following Cataract Surgery (NQF #0565). Although we believe the measure could be improved upon to reflect a higher level of visual acuity, it represents an important patient outcome following cataract procedure.

Measure Topics for Future Consideration

We applaud CMS’ proposed intention to address the following gap areas in outpatient quality measurement:

- Electronic clinical quality measures to advance information exchange
- Partial hospitalization measures to address the needs of individuals with acute psychiatric illness and prevent the need for (re)hospitalization
- Behavioral health measures, particularly for depression and alcohol use
- Other measures that align with CMS Quality Strategy and National Quality Strategy.

As an initial step, we recommend CMS continue to monitor measures from the physician performance reporting programs and the Meaningful Use of Health IT Incentive Program to identify outcome and patient-reported measures that can be applied appropriately in the hospital outpatient or ambulatory surgical center settings to address the priority areas noted above (e.g., [depression response at 12-months](#) for the outpatient setting).

Additionally, we detail specific priorities for filling measure gaps below, including measures of patient outcomes and patient safety, and measures of patient experience.

Measure of adverse outcomes from high-volume procedures

As an extension of the concept captured in the measure of hospital visits following colonoscopy, we urge CMS to consider the development of a measure that evaluates aggregate unplanned return visits to a provider following high-volume procedures performed in the outpatient hospital and ambulatory surgical center settings. In particular, we note that cataract removals, other minor eye procedures, endoscopies, musculoskeletal procedures, and colonoscopies account for approximately 74 percent of claims in the hospital outpatient setting, and 82 percent of claims in ASCs.^{iv} Patients want and deserve to know the likelihood that they will experience an unexpected complication following these high-volume procedures and the use of claims data could facilitate the identification of post-procedure visits outside of standard follow-up care.

Composite infection measure

We encourage CMS to prioritize improved patient safety and additional alignment across all care settings in the expansion of the OQR and ASCQR programs. In order to do so, we recommend the development of a composite measure of common surgical infections, including central line-associated blood stream infection (CLABSI), catheter-associated urinary tract infection (CAUTI), Clostridium difficile and Methicillin-resistant Staphylococcus aureus. These measures are all NQF-endorsed and are included in the Inpatient Quality Reporting Program, and corresponding, harmonized measures should be required in the OQR and ASCQR programs in the short-term – both individually (“drilled down”) and as a composite. Notably, these measures have also been supported by the Measure Applications Partnership as appropriate for a “family” of patient safety and care coordination measures suited for use across care settings.

CAHPS for the outpatient setting

We recognize with enthusiasm that CMS plans to begin testing for an outpatient/ambulatory surgery patient experience survey measure in 2014.^v We urge CMS to involve consumers and purchasers in the refinement of this measure and welcome the opportunity to contribute to this effort.

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the proposed regulations related to the Outpatient and Ambulatory Surgical Center Quality Reporting Programs. If you have any questions, please contact either of the Consumer-Purchaser Alliance’s co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely,
AARP
The Alliance
American Benefits Council
American Cancer Society Cancer Action Network
Caregiver Action Network
Center for Healthcare Decisions
Center for Medical Consumers
Consumers’ CHECKBOOK/Center for the Study of Services
Dallas-Fort Worth Business Group on Health
The Empowered Patient Coalition
Group Insurance Commission, Commonwealth of Massachusetts
HealthCare 21 Business Coalition

Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
Maine Health Management Coalition
Mothers Against Medical Error
National Coalition for Cancer Survivorship
National Partnership for Women & Families
Northeast Business Group on Health
Pacific Business Group on Health
St. Louis Area Business Health Coalition
Texas Business Group on Health
UNITE HERE Health
Virginia Business Coalition on Health
Wyoming Business Coalition on Health

ⁱ Elizabeth L. Munnich and Stephen T. Parente. Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up. *Health Affairs*, 33, no.5 (2014):764-769.

ⁱⁱ "Proposed New Quality Measure for the CY 2017 Payment Determination and Subsequent Years." 79 Federal Register 134 (14 July 2014), p. 41037.

ⁱⁱⁱ AGA Institute Polyp Surveillance Performance Measures. Available at http://www.gastro.org/practice/quality-initiatives/AGA_Institute_Polyp_Surveillance_Performance_Measures.pdf

^{iv} Munnich and Parente, 2014.

^v CMS. Outpatient/Ambulatory Surgery Patient Experience of Care Survey (O/ASPECS). Available at <http://cms.hhs.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/HOPD-ASC.html>.