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

June 12, 2007

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Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

File Code: CMS-1533-P (Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates)

RE: Comments on Medicare Hospital Reporting and Payment Policies:
- Hospital-Acquired Conditions, Including Infections
- Hospital Quality Data

Dear Ms. Norwalk:

The 24 undersigned organizations representing consumer, labor and purchaser interests appreciate the opportunity to comment on the proposed changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Rates. We applaud your efforts to foster increased transparency and promote a market that recognizes and rewards quality.

The comments that follow are based on our common belief that public reporting and appropriate financial incentives are core components needed to transform the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. Transparency and performance-based, differential payment must spur changes and foster a health care system that:
- Improves clinical quality;
- Addresses problems of underuse, overuse, and misuse of services;
- Encourages patient-centered care;
- Encourages care coordination and supports the integration and delivery of services for those with chronic illnesses;
- Reduces adverse events and improves patient safety;
- Avoids unnecessary costs in the delivery of care;
- Stimulates investments in structural components and the re-engineering of care processes system-wide;
- Avoids creating additional disparities in health care, works to reduce existing disparities, and encourages the provision of quality care for at-risk populations; and
- Provides meaningful performance information to consumers, providers, and others.

Below are our responses to specific issues raised in the two sections of the proposed rule pertaining to hospital-acquired conditions and hospital quality data.

DRGs: Hospital-Acquired Conditions

Measurement and differential, performance-based payments should support the evolution of the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. We applaud Medicare's efforts to ensure that hospitals are financially penalized for providing poor quality as a means of encouraging better care practices. Currently, complications, such as infections, acquired in a hospital qualify for higher payment in two ways. First, the treatment of complications can

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increase the cost of a hospital stay so that outlier payments are triggered. Second, for certain Diagnosis Related Groups (DRGs) the presence or absence of a complication or comorbidity can generate a higher Medicare payment. We believe that Medicare's payment practices need to be better aligned with desired performance.

The Deficit Reduction Act requires that for patients discharged on or after October 1, 2008, hospitals will not receive additional payments when certain conditions, designated by the Secretary, are not present at the time the patient is admitted. Thus, the hospital will be paid as though the avoidable complication had not occurred. The Secretary must select at least two conditions that are: (1) high cost or high volume or both; (2) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and (3) could have been reasonably prevented through the application of evidence-based guidelines.

We commend the Centers for Medicare and Medicaid Services (CMS) for proposing to include more than the statutory minimum of two conditions and support the six conditions proposed:

1. Catheter associated urinary tract infections
2. Pressure ulcers
3. Object left in after surgery
4. Air embolism
5. Blood incompatibility
6. Septicemia (staphylococcus aureus)

Paying for poor quality, preventable complications, or "never events" is not consistent with our shared goal to improve care. We encourage CMS to rapidly add to the number of complications that would be subject to nonpayment. It may be instructive to look at experience in the private sector (e.g., HealthPartners denial of payment for any National Quality Forum Never Event) or the upcoming HHS Office of Inspector General's report to inform the expansion of the list. In addition, we suggest that CMS explore a policy of non-payment for re-admissions where poor inpatient quality of care is a significant factor (see New York Times, May 17, 2007, In Bid for Better Care, Surgery with a Warranty[1]). Finally, we strongly urge CMS to add MRSA for present on admission (POA) reporting. MRSA infections are strongly and causally related to poor health outcomes and higher costs, and CMS should signal its interest in seeing hospitals take steps to avoid these infections; requiring reports is a good first step.

In addition, we draw your attention to a recently published report[2] that outlines how claims data could be enhanced to enable a better understanding of patient acuity and a more robust assessment of hospital performance. We ask CMS to act on these research findings by requiring hospitals to submit claims data augmented by numerical laboratory values at the time of patient admission. Further, we suggest CMS work to address the coding challenges highlighted in the proposed rule in order to better identify conditions and complications.

Comparative information should be available for all of the conditions listed on pages 191-192 of the notice, and we urge CMS to publicly report hospitals' performance on standardized outcome measures for preventable complications, including hospital-acquired infections. CMS should expedite the development of measures in those areas for which accountability measures are not yet available.

Hospital Quality Data

The Deficit Reduction Act provides a powerful financial incentive for hospitals to submit performance data to CMS for posting on Hospital Compare website (www.hospitalcompare.hhs.gov). A hospital that

[1] http://www.nytimes.com/2007/05/17/business/17quality.html?ex=1180411200&en=4a0be271429c7a5a&ei=5070
[2] Pine M, Jordan H, Elixhauser A et al. Enhancement of Claims Data to Improve Risk Adjustment of Hospital Mortality, JAMA. 2007; 297:71-76.

fails to submit performance information will have its annual Medicare payment update reduced by 2.0 percent. For Fiscal Year 2009, CMS is proposing to add the following five measures to the existing 27:

1. Pneumonia 30-day mortality (calculated with Medicare data only)
2. SCIP Infection 4: Cardiac Surgery Patients with Controlled 6 AM Postoperative Serum Glucose
3. SCIP Infection 6: Surgery Patients with Appropriate Hair Removal
4. SCIP Infection 7: Colorectal Patients with Immediate Postoperative Normothermia
5. SCIP Cardiovascular 2: Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period

While we support the five proposed measures, we urge CMS to rapidly incorporate additional measures for FY2009 to offer a more robust dashboard of publicly reported measures. We strongly support the inclusion of efficiency, outcome, outpatient (e.g., emergency care and ambulatory surgery), care coordination, patient safety, and structural measures. We also strongly support the development of measures to assess equity in order to reduce health care disparities and encourage the provision of quality care for at-risk populations.

Today, well-specified and endorsed measures are required to meet consumers' and purchasers' needs. Developing measures is a public good that requires significant financing from the public sector. To fill current measurement gaps (especially clinical outcomes, efficiency, patient-centered/continuum of care, and equity), the federal government should work with private funders to support the development and endorsement of a robust set of hospital performance measures. It should specifically support the rapid development of measures that are:

- Scientifically acceptable. Measures should be scientifically sound and evidence-based, but must not be held to unrealistically high academic standards that would delay the publication of good and useful information.
- Feasible to implement. Measures should be constructed and specified so that the data needed are currently available in electronic form or can be collected with limited reporting burden.
- Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must be a significant factor in the development of measures. Where possible, outcome measures are preferred. New evidence[3] shows currently endorsed hospital process measures are only loosely linked to outcomes. Where there is evidence strongly linking process measures to patient outcomes, process measures may be appropriate. An adequate and specified risk-adjustment strategy is also a critical requirement.
- 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.
- Address appropriateness of care. Measures are needed to assess whether or not the care provided to the patient was needed and whether patients got the needed care (e.g., measures of overuse of treatment of services should complement measures of underuse).

Composites measures increase the meaningfulness of health care performance information and are critical to help consumers integrate complex information into their decision making. Thus CMS should move rapidly to report composites on the Hospital Compare website while retaining the "drill down" function to permit a more granular assessment of performance.

Further we urge a stable source of financial assistance to support the core functions of the National Quality Forum. Such assistance is vital to sustain the activities of this consensus body that, reviews, endorses, and updates measures, among other important activities.

We are encouraged by the list of possible measures/measurement set for the RHQDAPU program for FY09 and subsequent years (pages 471-472). Many of the measures reflect aspects of care which have great interest to consumers and purchasers such as, clinical outcomes, efficiency, cross-cutting

[3] Werner, R.M., and E.T. Bradlow, "Relationship Between Medicare's Hospital Compare Performance Measures and Mortality Rates," *JAMA*, 296:22 (December 13, 1006), 2694-2702.

conditions, safety and structure. Also, the NQF Nursing Sensitive Measurement Set and measures that assess the care provided to "transfer patients" may be applicable to small and rural hospitals, and we hope that CMS will act favorably on such measures to broaden the ability of all hospitals to participate in public reporting and to increase the consumer appeal of the website. Further, reporting measures for the outpatient setting – Emergency Room and ambulatory surgery – on Hospital Compare would be responsive to consumer and purchaser needs.

Data Submission

CMS should continue to allow private sector organizations to have full access to provider performance information (numerator and denominator) from the Compare websites. Many plans rely heavily on the all-payer data to populate their provider selection tools; withholding or limiting access to granular performance data would impose additional reporting requirements on providers.

Retiring or Replacing RHQDAPU Program Quality Measures

We recognize the need to retire or replace measures. However, in doing so, we must guard against "backsliding" once a theoretical or real maximum has been achieved.

Public Display

Currently, Hospital Compare displays performance information that aggregates data across multiple hospital sites, a practice that diminishes the relevance of the information to consumers. CMS should provide comparative performance at the individual hospital level. The proposal to indicate which data reflect the performance of two or more hospitals is inadequate to aid in provider selection.

Thank you for the opportunity to comment on these proposed rules and for your leadership in this important area. If you have any questions, please contact either of the Disclosure Project's co-chairs, Peter Lee, CEO of the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AARP
American Hospice Foundation
Center for Medical Consumers
Childbirth Connection
Consumers Union
Employer Health Care Alliance Cooperative
ERISA Industry Committee
General Electric Company
Health Policy Corporation of Iowa
Hotel and Restaurant Employees International Union Welfare Fund
Iowa Health Buyers Alliance
Labor Management Health Care Coalition, Upper Midwest
Leapfrog Group
National Association of Health Data Organizations
National Business Coalition on Health
National Business Group on Health
National Consumers League
National Partnership for Women & Families
National Retail Federation
National Small Business Association
New Jersey Health Care Quality Institute
Pacific Business Group on Health
Service Employees International Union
St. Louis Area Business Health Coalition