

September 4, 2012

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

File code: CMS-1589-P

RE: Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot: Comments from National Consumer, Labor, and Employer Organizations

Dear Ms. Tavenner:

The 27 undersigned organizations representing consumer, labor and employer interests appreciate the opportunity to comment on the proposed rule updating the CY 2013 Hospital Outpatient Prospective Payment System. Our comments relate specifically to the Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) programs, as well as the Electronic Reporting Pilot.

In the years since the OQR first launched, we have applauded CMS' efforts to improve quality and value in the hospital outpatient setting by focusing on measures of safety, outcomes, and efficiency. With last year's implementation of the ASCQR, we again were very pleased to see alignment in measure selection across the Outpatient and Ambulatory Surgical Settings. Measures finalized for both the OQR and the ASCQR reflect CMS' focus on breaking down the silos across hospital and surgical settings in recognition that the same issues are of concern to consumers receiving care in both settings. The measures in these programs also reflect strong efforts to align with the many quality and safety initiatives included in the *Affordable Care Act (ACA)*, the Meaningful Use of Health IT incentive program, the *National Quality Strategy*, and the *Partnership for Patients*.

The CY 2013 proposed rule includes neither new measures for either program, nor potential measure topics for future rulemaking. Given CMS' engagement in the *Measure Applications Partnership (MAP)*, we are concerned that CMS did not address the recommendations in MAP's February 2012 pre-rulemaking report to HHS¹. The MAP recommended that CMS identify measures included in clinician reporting programs that could be harmonized with the OQR (MAP, 2012, page 93). The MAP report also stated that the OQR would benefit from adding measures related to supporting better health in communities, making care more affordable, and person- and family-centered care. We strongly support both sets of recommendations, and in our comments below we offer specific suggestions for measures that address them.

¹ MAP Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012, www.qualityforum.org

The following comments pertain to sections XV and XVI of the NPRM, covering the Outpatient Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, and the EHR Pilot Program.

Recommended OQR and ASCQR Measures for CY 2015

We commend CMS' intention to focus on outcomes, efficiency and patient experience in selecting measures for the OQR. We note that a number of gaps still remain to be addressed in the program. Regrettably, the proposed rule does not identify potential measures to fill those gaps that could be in the OQR or ASCQR in the future. Measure gaps (both in terms of what measures the field is missing, as well as what gaps exist in measure implementation) have been a subject of much discussion at the MAP, with much identification and prioritization already accomplished. As a result, there is consensus around the fact that measures of clinical quality, care coordination, patient safety, patient and caregiver experience, population/community health, and efficiency are sorely needed. Accordingly, we offer recommendations that we believe are aligned with the MAP recommendations – such as measures relevant to clinicians and measures of patient-centeredness – as well as with the goals of the *National Quality Strategy*:

- **In the OQR and the ACSQR programs, add a tool for measuring patients' experience of care and require that it be reported to qualify for the annual payment update.** We note with concern that – with the exception of the HCAHPS survey requirement for the IQR – patient experience measures are missing from the CMS's proposal for pay-for-reporting initiatives. Reports from patients on their own and their family caregiver's experiences are invaluable to understanding the effectiveness of care coordination, care transitions, and medication safety efforts. Further, given the paucity of comprehensive outcome measures, it is especially important that CMS take advantage of existing patient experience survey instruments that are directly correlated with better outcomes. While there is not yet a CAHPS version specifically tailored to the outpatient or ambulatory surgical care settings, we suggest that CMS quickly explore, with the Agency for Healthcare Research and Quality (AHRQ), how HCAHPS, the Clinician/Group CAHPS, or the CAHPS Surgical Care Survey could be specified for the outpatient arena. We appreciate that CMS has listed the CAHPS tool as a measure under consideration, and we would strongly suggest making it a top priority. We also recommend that CMS consider adding the Care Transition Measure 3-question survey to the OQR as well, to align with the newly added CTM component to HCAHPS in the Inpatient Quality Reporting (IQR) program.
- **In the OQR and ASCQR programs, add a measure of central-line associated blood stream infection (CLABSI).** We applaud the finalization of the surgical site infection measure in last year's OQR and ASCQR programs. To complement this measure and create additional alignment across hospital settings, we recommend adding the CDC's measure of rate of CLABSI, using the National Health Safety Network database. Adding this measure will also bring the outpatient setting in line with the recommendations made in the January 2009 Department of Health and Human Services report, "*Action Plan to Prevent Healthcare-Associated Infections.*" This report includes a number of additional hospital-acquired infection measures – such as CLABSI – that are crucial to reducing infection rates and improving patient safety and outcomes. Because central lines are commonly used in the outpatient setting, particularly in the delivery of chemotherapy protocols, this measure is extremely relevant to the OQR. We also urge CMS to implement in both programs a core patient safety measure set that includes Central Line Bundle Compliance, c-difficile, catheter-associated urinary tract infection (CAUTI), and MRSA. These measures are all either currently, or soon to be, implemented in the IQR, and corresponding,

harmonized measures should be required in the OQR and ASCQR programs. These measures have also been supported by the MAP's patient safety-care coordination task force for inclusion in a patient safety family of measures.

- **Add relevant clinician measures to the OQR program.** CMS should look to clinician-level measures in its physician performance reporting programs, as well as the Meaningful Use of Health IT Incentive program, to identify meaningful clinician-level measures that can be applied appropriately at the hospital outpatient setting for conditions such as diabetes, coronary artery disease, and COPD. We offer the following recommendations that reflect the MAP's recommendation to add relevant clinician measure to the OQR:
 - Diabetes: In our comments on the CY 2011 and CY 2012 OPSS proposed rules, we supported the addition of a number of diabetes measures to the OQR, but they were not finalized by CMS. Given the significant percentage of diabetes-related primary care services are provided in the hospital outpatient clinic setting, we recommend adding diabetes measures, such as the Minnesota Community Measurement "Optimal Diabetes Care" composite (NQF #0729). For patients with diabetes who are treated in a hospital outpatient department, 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.
 - Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD): Similar to diabetes, a high percentage of patients are now receiving primary/ambulatory care for COPD and CAD in outpatient settings. We recommend adding the Composite of Chronic Prevention Quality Indicators that has been developed for use in the Physician Value-Based Payment Modifier program, to the OQR. This composite includes measures related to COPD, heart failure, and diabetes.
 - Depression: Depression was named the top priority for measure development and implementation by a National Quality Forum advisory committee seeking consensus around prioritization for the Medicare population. Thus, we recommend implementing the PHQ-9, a functional status measure that screens for depression, to the OQR. It is widely in use in the public (nursing home payment) and private (ACOs, regional collaboratives) sectors.
 - Patient-Reported Outcomes Measures: In addition to the patient experience of care measures referenced above, we recommend adding measures of patient-reported health status/outcomes to the OQR. One highly successful example is the Patient-Reported Outcomes Measure Information System (PROMIS), which comprises a system of highly reliable, precise measures of patient reported health status for physical, mental and social well-being. Another example in this category, which relates more specifically to functional status, is the VR-12, a health-related quality of life survey that can be applied across multiple conditions.

CY 2013 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs

Last year's OPSS proposed rule outlined a pilot that would allow hospitals participating in the Meaningful Use (MU) program to meet the MU quality reporting requirements through a single submission for the IQR, OQR and MU programs. We continue to support the advancement and use of e-

measures. However, we continue to have the concerns that we expressed in our comments on last year's OPSS proposed rule: 1) the pilot will require eligible hospitals to submit patient-level clinical quality measure data which is inconsistent with the requirement in the Meaningful Use program to report summary-level data and could have adverse consequences for patient privacy ; and 2) the pilot requires reporting only Medicare data, which represents a step backward from the positive trend over the last decade for hospitals to submit all-payer quality data to CMS. The availability of patient data, regardless of payer, is instrumental to meeting the goals outlined in the National Quality Strategy and the Partnership for Patients initiative. Further, the lack of all-payer data could erode the utility of the Hospital Compare website, which now reports all-payer data for a majority of measures. We believe that reporting should be consistent with the Meaningful Use program, which requires reporting of all-payer data. It will be counter-productive to implement two different reporting methodologies for these programs.

This year's proposed rule does not provide any clarification or assessment of how the pilot has worked thus far, and simply states that CMS will continue the pilot for the coming year. We urge CMS to publish a comprehensive assessment of the pilot's effects on data collection, both in terms of patient privacy and on how the pilot has affected the availability of all-payer data from participating hospitals.

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, and the Hospital Value-Based Purchasing Program. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project'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
AFL-CIO
The Alliance
American Benefits Council
American Federation of State, County & Municipal Employees
American Hospice Foundation
Business Healthcare Group of Southeast Wisconsin
CalPERS
Childbirth Connection
Culinary Health Fund
The Empowered Patient Coalition
Employers' Coalition on Health
Greater Detroit Area Health Council
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
The Leapfrog Group
Massachusetts Group Insurance Commission
Minnesota Health Action Group
National Business Coalition on Health

National Family Caregiver Alliance
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Pacific Business Group on Health
PULSE of America
St. Louis Area Business Health Coalition
Unite HERE Health