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

June 18, 2010

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

File Code: **CMS-1498-P (Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates)**

RE: **Comments on Changes to the Reporting of Hospital Quality Data for Annual Hospital Payment Update (RHQDAPU) Program**

Dear Ms. Tavenner:

The 30 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, in particular, the Reporting of Hospital Quality Data for Annual Payment Update (RHQDAPU) program for Fiscal Year 2011. We continue to commend the efforts of the Centers for Medicare and Medicaid Services (CMS) to foster increased transparency and promote a market that recognizes and rewards quality. With the passage of the Affordable Care Act (ACA), as well as the 2009 American Reinvestment and Recovery Act (ARRA) meaningful use program, the concept of paying providers based on value, rather than volume, has expanded beyond RHQDAPU, and has come to encompass such concepts as data collection via electronic health records (EHRs), value-based purchasing for both hospitals and physicians, and episode-based payments. We look forward to working with CMS and other partners as we seek alignment on all of these related programs.

Our comments pertain to issues raised in the section of the proposed rule on the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program:

- **Overall, we support many of the proposed changes that CMS describes**, and believe they will greatly improve the RHQDAPU program's contribution to improving quality and making information publicly available to consumers and purchasers. In particular, we laud the decision to add healthcare-acquired conditions and infections (HACs and HAIs), and registry-based measures to the requirements for the payment update.
- **There are some areas where we express concerns, including**: 1) the proposal to allow hospitals to choose one out of four measure topic areas beginning in FY 2013; 2) the absence of any reference to aligning RHQDAPU's inclusion of healthcare-acquired infection measures with the metrics in the HHS *Action Plan to Prevent Healthcare-Associated Infections,* which are slated for inclusion in the ACA's Hospital Value-based Purchasing program; and 3) the delayed inclusion of measures of use of the surgical check-list, care transitions, and end-of-life care.

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Retirement of RHQDAPU Program Measures

General Measure Retirement Criteria and Concerns: In response to CMS' request for comments regarding criteria for measure retirement, we continue to support the criteria that were described in the FY 2010 final rule: namely, measures that have been shown to have unintended negative consequences for certain patient populations, and measures where the evidence base has changed, should be proposed for retirement.

In regard to measures where performance has reached virtually 100 percent compliance, we do not necessarily consider this a reason for retiring a measure, because consumers and purchasers may still be interested in seeing comparative information for many of these measures. However, we do recognize the need to make room for new measures. We suggest that CMS develop a method for rotating certain "topped out" measures, whereby these measures would still be collected and reported but not on an annual cycle (e.g. every three years), to ensure that quality in these areas does not "slip." We note that in the FY 2010 Final IPPS rule, it was recommended that CMS implement an ongoing surveillance mechanism for measures that are retired to ensure sustained high performance. CMS responded that it did not have mechanisms available to conduct continued surveillance of retired measures, but committed to explore options for monitoring whether the performance on retired measures deteriorates over time. We suggest that this concept of requiring periodic reporting could be an element of such a surveillance system.

Retirement of Specific Measures: We support CMS' proposal to retire the "Mortality for Selected Surgical Procedures" measure, based on the National Quality Forum's evaluation that the measure is not suitable for public reporting. We believe this also meets a criterion stated above. However, we urge CMS to replace this with a different surgical procedures mortality measure, as the measure focus is salient to consumers as well as clinically important. We suggest that CMS consider the National Surgery Quality Improvement Project, which has been in place since 1994 to monitor and improve the quality of surgical care across all Veterans' Administration medical centers, as a potential replacement to the AHRQ mortality measure. Since 2004, the project has been overseen in the private sector by the American College of Surgeons, and has been named "the best in the nation" by the Institute of Medicine for measuring and reporting surgical quality and outcomes.

To create room for new measures that could provide useful information to consumers, and potentially, stimulate improvement in other areas, we support putting four of the seven measures identified as being "topped out" into a rotation strategy as described above. These measures reflect practices that are currently accepted and expected, but we would like to see hospitals continue to collect and report on the data periodically (rather than annually) to ensure quality remains high. These four include:

- AMI-6: Aspirin at Arrival
- AMI-3 ACEI/ARB for left ventricular systolic dysfunction
- AMI-5: Beta-blocker prescribed at discharge
- SCIP-Infection-6: Surgery patients with appropriate hair removal

In the case of the three "Adult Smoking Cessation Advice/Counseling" measures, each specified for a different condition, we recommend retiring them altogether, rather than putting them in a rotation. As currently specified, each of these measures simply requires checking a box, and is a poor indicator of the quality of advice and counseling received by the patient. We urge CMS to develop a more meaningful all-condition global smoking measure to evaluate how well hospitals provide smoking cessation counseling.

Finally, we support the retirement of the four measures identified in the FY 2010 Final Rule as having either a weak relationship to better outcomes, impose too great a data collection burden, or are inconsistent with current guidelines. Below are comments on specific measures:

- *HF-1: Discharge Instructions*: We agree and understand that the Discharge Instructions measure (HF-1) is inappropriate for RHQDAPU. In its place, we strongly urge CMS to identify a patient-centered measure that evaluates whether proper care transitions were provided to patients (for heart failure and other conditions). Our support for retirement of HF-1 does not signify erosion in our support for measurement of care transitions from RHQDAPU. Knowing – from the patients' perspective – whether she received the information she needed to ensure proper care post-discharge is critical to outcomes and, particularly, to reducing hospital readmission rates. Providing patients with this information is also a fundamental component of what we would like to see in the final meaningful use requirements.

- *SCIP Infection-2: Prophylactic Antibiotic Selection for Surgical Patients*: Given that in FY 2013, CMS is proposing to include a surgical site infection rate measure that is more closely related to outcomes than the SCIP-2 measure, we agree with the proposal to retire it.

- *PN-2 and PN-7: Pneumococcal Vaccination and Influenza Vaccination*: We support retirement of the current pneumonia and influenza vaccination measures with the expectation that CMS will add the global pneumonia and influenza vaccination measures. These are currently proposed for implementation in FY 2014, but to eliminate a gap in measurement in this area, we encourage CMS to add these to RHQDAPU in FY 2012, when the current vaccine measures will be retired.

Proposed Plan to Lay Out Expansion of Quality Measures for the FY 2012, FY 2013, and FY 2014 Payment Determination (Three-year Plan)

Consumers, labor, and employer organizations fully support the concept laid out in the proposed rule for developing a three-year plan for RHQDAPU. We agree with CMS' contention that this would provide greater certainty for hospitals in future planning and give them more time to prepare for additions to the RHQDAPU program. However, the many impending changes to the health care delivery system arising from passage of the Affordable Care Act (ACA) and the American Reinvestment and Recovery Act's Health Information Technology for Economic and Clinical Health (HITECH) Act (notably, the meaningful use provisions) are not mentioned in the proposed rule in relation to the three-year plan. If CMS decides to proceed with a three-year cycle, it will have to modify the RHQDAPU in accordance with emerging regulations and implementation policies to ensure full alignment with HITECH and ACA, and we assume this is CMS' intention. We also strongly urge continued solicitation of public comment on the RHQDAPU elements designated for FY 2013 and FY 2014 that appear in the FY 2011 final rule so that CMS can make necessary changes in response to experiences with the measures.

Proposed Expansions to RHQDAPU Program Quality Measures

We support all of the measures designated for FY 2012, FY 2013, and FY 2014. Specific comments for each fiscal year follow.

FY 2012: We support the addition of AHRQ Patient Safety Indicators *PSI-11:Post-operative Respiratory Failure* and *PSI-12: Post-operative Pulmonary Embolism or Deep Vein Thrombosis*. In addition, we applaud CMS' proposal to add the eight healthcare-acquired conditions (HACs) that are now part of the Medicare non-payment program to RHQDAPU. The addition of these eight HACs for the payment update is a significant step toward improving patient safety and patient outcomes, and reducing the level of HACs in the nation's hospitals. We understand that public reporting of these events can be a challenge, and we encourage CMS to look to the work that the National Quality Forum is overseeing in developing a framework for how to report serious reportable events for guidance.

FY 2013: We fully support adding the *AMI-Statin at Discharge* measure, as well as the two healthcare-acquired infection (HAI) measures, *Central Line Associated Blood Stream Infection (CLABSI) and Surgical Site Infection (SSI)*. In January 2009, the Department of Health and Human Services released the "Action Plan to Prevent Healthcare-Associated Infections" report, which lists a number of HAI metrics that will be crucial to developing a roadmap for prevention of infections. We note that the ACA provisions on hospital value-based purchasing (VBP) require that all of the metrics included in the Action Plan be integrated into the VBP program by FY 2013, and that the metrics used for VBP must be reported on Hospital Compare for at least one year. Thus, for CMS to implement the VBP measures for all of the metrics listed in the Action Plan, it would need to implement them in RHQDAPU in FY 2011, so that hospitals have one year to collect data, and the measures have a year's worth of experience on Hospital Compare. Given this challenging timeline, we urge CMS to move up the implementation of the CLABSI and SSI measures to FY 2011, and phase in the additional Action Plan metrics in FY 2012 and FY 2013, in order to align the RHQDAPU program with the hospital VBP program, as mandated by ACA. The HHS Action Plan metrics not listed in the RHQDAPU proposed rule include the following:

- Central Line Bundle Compliance
- Clostridium Difficile 1 and Clostridium Difficile 2
- Number of symptomatic catheter-associated UTIs per 1,000 urinary catheter days
- MRSA 1 (incidence rate per 100,000 persons of invasive MRSA infection)
- MRSA 2 (related to facility-wide healthcare facility-onset MRSA)

Finally, as noted in the proposed rule, in FY 2013 CMS proposes the addition of a number of registry-based measures. We address registries separately below.

FY 2014: We support the two emergency department throughput measures proposed for addition to RHQDAPU in FY 2014, for the same reasons specified in the proposed rule: these measures reflect both emergency department processes – which directly can affect patient outcomes and patient safety – as well as care coordination and efficiency of care provided throughout a hospital setting. Regarding the two additional measures proposed for FY 2014 – global pneumonia vaccination and global influenza vaccination – we support these measures, but as noted earlier in this letter, we encourage CMS to consider implementing them in FY 2012, assuming that the proposed retirement of the current pneumonia and influenza vaccination measures in that year occurs as scheduled.

Possible Future Measures and Topics: We are very pleased to see the inclusion of the surgical checklist, care transitions, mortality, and end-of-life as measure topics being considered by CMS for inclusion in RHQDAPU. However, we are dismayed that the earliest these measures could be implemented is FY 2015, because they are so critically needed and meaningful to consumers. In the case where there are already specific measures listed for future years, such as the care transition measures, we urge CMS to implement them by FY 2013. In cases where there are not yet specific measures developed and tested, we urge CMS to work with developers to fill these gaps.

All-patient Volume Reporting for MS-DRGs

Consumers and purchasers have long advocated for Medicare to align quality measurement with the activities of those measuring care in the non-Medicare population. CMS has responded by requiring that process measures that rely on chart-abstracted data be collected and reported for a hospital's entire inpatient population. In that regard, we believe that the requirement for hospitals to submit all-patient volume data for the 55 MS-DRGs that relate to RHQDAPU measures is important to allow for better understanding of the relationship between volume and quality of care across all populations. To make the collection of all-patient data even more relevant, we urge CMS to add to the RHQDAPU program the required collection of all-patient/all-payer cost data for the RHQDAPU-relevant MS-DRGs as well. We strongly believe that measures developed by CMS should apply to the non-Medicare population to support better alignment as well.

Proposed New Registry-Based Measures

CMS proposes that hospitals be allowed to choose one of the following four proposed measure topics: ICD complications, cardiac surgery, stroke, or nursing-sensitive care. Consumers and purchasers strongly support the addition of registry-based measures to the RHQDAPU program. We view this addition as a long-overdue step toward public reporting of registry data, and support the measures included in each of the topic areas. As quality measurement and improvement becomes more focused on outcomes, it is essential to take advantage of the wealth of information collected through registries. We understand that there are a number of concerns expressed by providers regarding making registry participation a requirement for the annual payment update, including concerns about the cost of participating in registry databases. Further, we are aware of hospitals' concerns regarding the registry measures to assess ICD complications and the cardiac surgery topics that would involve deeming just a single registry to fulfill the RHQDAPU requirements. We believe CMS could take steps to mitigate these concerns. For example, CMS should ensure that registry fees for the selected registries are reasonable and do not impose a barrier to participating in the program. CMS might also consider ways in which the risk adjustment methodology could be made available to all registries, thereby permitting multiple registry sponsors to participate in RHQDAPU. Receiving a registry's assurance that it would use that risk adjustment methodology would be an additional factor to add to the qualification criteria identified in the proposed rule. This strategy would allow hospitals to freely select a registry and it would eliminate the concern that small, regional registries, which have been very successful for many hospitals, would be put out of business by this new policy.

While we are in favor of including registry-based measures in RHQDAPU, we are opposed to the manner CMS has proposed to implement such measures. We object to allowing each hospital to choose its own measurement topic, as well as requiring reporting of just a single measure using registry data. Accordingly, we strongly urge CMS to rethink this concept. Allowing hospitals to choose just one clinical area will make it impossible for consumers and purchasers to compare hospitals, thus weakening the usefulness of the information. In addition, there are no criteria described in the proposed rule for how a hospital would choose which clinical area to report. If there are no criteria, we fear that hospitals will simply choose the area in which they have achieved the highest performance. Consumers need to be able to compare the same information across all hospitals, when it is applicable. Creating a situation where users cannot make apples-to-apples comparisons will undermine use of *Hospital Compare*.

As an alternative, we recommend CMS implement two measure topics in FY 2013: nursing-sensitive care and cardiac surgery. Nursing-sensitive care has been overshadowed in the realm of quality reporting and is a critical element of quality care delivery. Cardiac surgery is high-volume, and hospitals are most likely already participating in cardiac surgery registries and have experience with collecting the type of data necessary for the measures listed in this set. We recommend that CMS phase in the additional registry-based measure topics proposed in this rule, one per year.

RHQDAPU Requirements That Involve Disparate Data Collection Systems

With the addition of the HAC measures, the MS-DRG volume data for all-patients, the HAI measures, and the registry-based measures, we appreciate the potential for burden that may be faced by hospitals having to support and maintain multiple data collection and reporting systems. However, rather than arguing against the implementation of these measures due to disparate data collection systems, we see this as a huge opportunity to address flaws in the current environment, in which data exist in silos. The ultimate solution to this problem is the collection of EHR-transmitted data. We support CMS's commitment to enhancing its capability to collect data electronically, and we urge CMS to move forward as quickly as possible to meet this commitment.

Proposed HCAHPS Requirements for FY 2012, FY 2013 and FY 2014 Payment Determinations

The collection of patient experience data through the HCAHPS survey tool and its reporting on Hospital Compare are absolutely critical to the improvement and understanding of how a hospital engages patients, communicates, and generally addresses patient, family, and caregiver needs and experiences. We fully support the continued requirement of HCAHPS reporting to be eligible for the full payment update. At the same time, we urge CMS to address the gaps that still exist in HCAHPS,

including domains related to patients' experiences with care coordination and care transitions, functional status, and expanded questions on communications. We ask that CMS provide funding to the Agency for Healthcare Quality and Research to conduct the necessary development and testing of additional refinements to HCAHPS.

Qualification of Registries for RHQDAPU Data Submission

We want to stress the importance of retaining the qualification criteria for registries and note, in particular, the need for registry data to be auditable. The proposed rule includes a criterion that the registry must be able to perform data quality validation checks on the data received from hospitals to determine if it is accurate. We strongly suggest that the requirements around auditing processes be very specific, and include a mandate that the auditing process be fully transparent to allow stakeholders to clearly assess the data's reliability.

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, 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,

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