

June 13, 2008

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

File Code: CMS-1390-P (Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates)

RE: Comments on Medicare Hospital Reporting and Payment Policies:

- Hospital-Acquired Conditions, Including Infections
- Reporting of Hospital Quality Data for Annual Hospital Payment Update
- Hospital Value-Based Purchasing

Dear Mr. Weems:

The 25 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 2009 Rates. We specifically want to commend CMS' efforts to foster increased transparency and promote a market that recognizes and rewards quality. By adding nine new Hospital Acquired Conditions (HACs) for which hospitals will not receive reimbursement, and 43 new measures for which hospitals must report in order to receive their full annual payment update, CMS is playing a significant role in advancing the goal of creating a performance-based health care system.

The comments that follow are based on our common belief that measurement, performance feedback, 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. Public accountability for performance and differential performance-based payment are critical to creating incentives that can 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 across providers and care settings, particularly for 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;
- Reduces disparities in health care 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 three sections of the proposed rule pertaining to hospital-acquired conditions, hospital quality data reporting, and value-based purchasing.

Section II.F: Hospital-Acquired Conditions (HACs)

The 2005 Deficit Reduction Act (DRA) required CMS to select two hospital-acquired conditions that would be subject to non-payment. We commend CMS for continuing to go beyond the statutory minimum of two conditions by proposing the addition of nine new HACs to the existing eight HACs for which CMS no longer provides additional payments to hospitals. Because of the considerable morbidity, mortality and staggering health care costs due to preventable hospital acquired conditions, we strongly support imposing the risk of financial penalty to encourage hospitals to engage in better care practices. Non-payment can be an enormously important tool for improving quality. At the same time, we are mindful that under the CMS construct non-payment does not translate into *zero* payment for care, but rather the absence of additional payment for preventable complications that arise in the hospital. We support CMS considering in its deliberations of the proposed and future HACs for non-payment (1) the ability of the hospital to prevent the event; (2) the ability to validly collect data on the incidence of the events; and (3) that coding and data collection issues are addressed, thus allowing non-payment to be implemented in a way that is fair and clinically sound. We feel it is critical that CMS take the lead in this area.

We favor CMS' consideration of all nine of the HACs listed in the proposed rule, but there are specific conditions for which we want to underscore our support:

- *Surgical site infections following elective procedures (Total Knee Replacement, Laparoscopic Gastric Bypass and Gastroenterostomy, and Ligation and Stripping of Varicose Veins):* Surgical site infections are preventable and are excellent candidates for being publicly reported as well as having payment reduced. The three procedures listed here are done frequently, and are generally elective; thus consumers should be able to select providers who have the fewest number of errors or complications.
- *Iatrogenic Pneumothorax:* The breadth of procedures in which Iatrogenic Pneumothorax may possibly occur makes it an appropriate candidate for non-payment, given the broad implications for patient safety and outcomes.
- *Ventilator Associated Pneumonia:* Complications due to VAP are serious, relatively frequent, and add significantly to the cost of care.
- *Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE):* Analysis by MedPAC indicates that the rate of post-operative DVT/PE has worsened in the Medicare population.

We also recommend that CMS explore a policy of non-payment for re-admissions where poor inpatient quality of care is a significant factor. According to the Medicare Payment Advisory Commission, nearly 18 percent of hospitalized Medicare patients are readmitted to a hospital within 30 days of discharge at a cost of \$15 billion annually. We also recommend that CMS explore "warranty" models such as the one adopted by Geisinger Health System (GHS), which places a 90-day warranty on care provided to all non-emergency coronary artery bypass graft (CABG) patients, charging a single price for a bundle of services that includes readmissions for complications. A study found that those patients treated under the "warranty" in 2005 were more apt to receive appropriate evidence-based care and experienced 5.2 percent lower hospital charges, a 12 percent decrease in average length of stay, and a slight reduction in complication rates.¹ While this model may not be fully generalizable, it is worthy of consideration.

¹ Casale AS, et al., "ProvenCare, A Provider Driven Pay for Performance Program for Acute Episodic Cardiac Surgical Care," Geisinger Health System, Danville, PA. www.americansurgical.info/abstracts/2007/20.cgi

Regarding MRSA, we are in support of strategies that will increase the monitoring and prevention of MRSA – adding MRSA to the list of HACs for non-payment is one such important strategy. We acknowledge that this will not be possible until coding is available to monitor its occurrence accurately, thus we urge improved coding be rapidly implemented in order to meet this need. MRSA does pose a threat to the health and mortality of those receiving inpatient care, and reducing its occurrence should be actively pursued by hospitals. While it is true that many individuals are carriers of a latent form of MRSA, the percentage of individuals with active cases is much smaller, and there are actions that can be done within the hospital setting to prevent MRSA from spreading.

Additional Comments

Present on Admission (POA) Coding: We support the new rule to modify and attach incentives to POA coding. To ensure that this policy change has a significant impact, we strongly encourage that the new coding be monitored to assure accuracy, and that auditing be a core component. In the absence of such provisions, the potential for “gaming” could result in undercutting reporting efforts. In addition, we suggest that the baseline data from the period before non-payment be compared with data after non-payment to provide insight on coding practices. In terms of how to report the data that stems from these POA coding reforms, we suggest looking at creating a composite of all “never events,” using longitudinal data, and reporting numerator and denominator to ensure the clarity of the results.

- **Adoption of the ICD-10-CM:** The proposed rule discusses the potential adoption of the ICD-10-CM in place of the current ICD-9-CM. We strongly encourage CMS to adopt the ICD-10-CM, which will enable more exact coding and monitoring of inpatient conditions, thereby leading to both improved data collection, more precise identification of HACs, and improved health outcomes.
- **Risk Adjustment for Serious, Reportable “Never” Events:** We are opposed to the concept of risk adjusting for “never” events and feel that for many such events – such as wrong site surgery – it is wholly unnecessary and a waste of resources. We would argue that all patients, regardless of health status, should expect an inpatient stay free from serious reportable events such as performing surgery on the wrong body part or wrong patient, or leaving a foreign object inside the patient after surgery. In the case of Surgical Site Infections, there may be procedures for which staging and categorizing the complexity of patients may be needed to assure that providers do not avoid more complex patients.

Section IV.B: Reporting of Hospital Quality Data for Annual Hospital Payment Update

The undersigned strongly supports publicly reporting information that will improve care, increase patient safety, and foster high performance within the health care system. We strongly support CMS pursuing the inclusion of these 43 measures in FY 2010.

Additional Comments

- **Including the AHRQ measures:** We applaud CMS for including the AHRQ Patient Safety Indicators and Inpatient Quality Indicators that were recently endorsed by the National Quality Forum. These are important indicators of safety and quality problems, and are the kind of measures that Medicare beneficiaries and other consumers can rely on to help them make better informed choices. Moreover, they are easily collected using already existing administrative data with no additional burden to hospitals.
- **Collecting AHRQ Data:** In response to data collection methods for the AHRQ measures we strongly encourage CMS to 1) use all-payer data; and 2) collect that data through third-party intermediaries that are already receiving it from hospitals in 40 states. Allowing this option

will streamline the process for the majority of hospitals already using a third-party intermediary for these measures. CMS should put mechanisms in place to ensure the accuracy of the third-party data.

Additionally, we strongly support CMS requiring hospitals to submit claims data augmented by numerical laboratory values at the time of patient admission. Research findings published in the Journal of the American Medical Association earlier this year outline how claims data can be used to enable a better understanding of patient acuity and a more robust assessment of hospital performance.

- **Other measures for inclusion:** We suggest additional measures addressing infections due to medical care and post-operative sepsis. We also suggest adding measures addressing ICU mortality, which is currently included in the list of measures publicly reported on CalHospitalCompare.org as part of the California Hospital Assessment and Reporting Taskforce (CHART) project.

There appears to be a notable gap in measures that address efficiency, a core element of the Institute of Medicine's six aims for quality health care. While we support the inclusion of the three readmission measures, we suggest CMS pursue adoption of NQF-endorsed measures on Length of Stay as well as broader measures addressing cost and resource use.

- **Broadening scope of measures:** As measures are developed, they should be inclusive of all relevant age groups. Two examples of this are Pediatric ICU measures, which have been endorsed by the National Quality Forum and adopted by the HQA, and maternal and perinatal care measures which are currently undergoing NQF review for endorsement. In addition, we encourage CMS to create an infrastructure that allows data collection and transmission and public reporting of measures such as these, regardless of whether the population they address overlaps with the Medicare population.
- **Hospital Burden:** The proposed increase in measures on which hospitals would be required to report in order to get their full annual payment may be viewed by hospitals as burdensome in the current chart abstraction-based world; however, CMS' actions to broaden the measure set should spur hospitals to invest in electronic information systems that support quality measurement and improvement. CMS should look at this as an opportunity to require electronic reporting and define a clear timeframe for making this the standard for both data collection and reporting. The final IPPS rule could include language that within a set period of time (e.g. three years), any measure that goes live will have to be submitted electronically. Rather than limiting the number of measures used, we believe electronic information is the efficient solution for supporting an effective quality improvement environment within a hospital. Hospitals cannot improve what they cannot track.
- **Public Display on Hospital Compare:** CMS proposes to indicate on Hospital Compare when performance measures combine results from two or more hospitals that share the same Medicare Provider Number. However, this type of data display will not allow consumers and purchasers to best assess the information and use it, thereby reducing the effectiveness of Hospital Compare. We know that "related" hospitals do experience different results, and urge CMS to 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.

Furthermore, we urge CMS to more effectively display data on Hospital Compare to enable consumers to discriminate among hospitals based on their performance. Strategies may include developing composite measures reflective of overall quality, and other data display techniques (using deciles, etc.) to show variation in quality. Where performance strata

depend on statistical confidence intervals, Medicare beneficiaries should be included in the process of determining what level of confidence is appropriate for their decision-making. As the number of measures added to the RHQDAPU continues to grow, this will become increasingly important if CMS wants Hospital Compare to be a source of useful information for consumers.

- **Racial and Ethnic Data Collection:** We support the collection of race, ethnicity, gender and other data (e.g. education, income, sickness burden) that will enable CMS to examine issues of equity. We encourage CMS to refer to three tools in this endeavor: 1) the Health Research and Educational Trust (HRET) Disparities Toolkit, which is currently under review by the National Quality Forum; 2) the Quality Alliance Steering Committee (QASC); and 3) the National Quality Forum's Voluntary Consensus Standards for Ambulatory and Hospital Care: Measuring Health Care Disparities. The HRET Disparities Toolkit lays out a systematic methodology for collecting race, ethnicity, and primary language data from patients, the QASC is working on strategies for how to address disparities in data collection, and the NQF measures provide a core set of measures that reflect a mix of chronic conditions, prenatal care, prevention, and patient experience. To the extent that the data enable CMS to produce stratified performance results by various sub-populations, we encourage CMS to set performance improvement targets that are financially incentivized to drive reductions in the disparities gaps.
- **Data Collection Entities:** We are very pleased to see the inclusion of administrative measures and use of registries. We have concern about a program that relies heavily on medical chart review and the incorporation of these additional data collection methods are very important for sustainability of the program.
- **Measure Retirement:** CMS proposes discontinuing the requirement that hospitals report the Pneumonia Oxygenation Assessment measure, given the high compliance. This raises an interesting question, given that other measures may come under the same umbrella in the coming years. We recommend that CMS monitor hospital performance by having hospitals continue to report on these measures, but that the data not be publicly reported unless backsliding becomes apparent. The re-introduction of this and future "retired" measures could place more of a burden on hospitals than if they just were to continue reporting it.
- **Use of Sub-Regulatory Process to Update Measure Specifications:** We appreciate CMS addressing the need to be flexible when it comes to changing a measure's technical specifications through the QualityNet website. We suggest CMS provide more details on the potential sub-regulatory process, such as developing criteria that would specifically describe terms such as a "small technical" change as opposed to one that is "material or substantive."

Section IV.C: Medicare Hospital Value-Based Purchasing (VBP) Plan

CMS has requested comments on how to take full advantage of the information gathered through the pilot testing of the VBP Plan's use of clinical process measures and HCAHPS data. We are not clear on what CMS means by "testing," and would argue that measures that have already been endorsed by NQF (except for those with "time limited" endorsement) do not need to be tested. Finally, we recommend that since all the measures in the RHQDAPU have already been tested, used, and publicly reported, that there be no "transition" for those measures. They should be ready to be implemented into a new VBP framework immediately.

In terms of the testing process itself – for those new measures that do need to be tested – we suggest that the comment period for the pilot testing results be brief in order to keep the process moving efficiently. We encourage CMS to consider the fact that not all measures related to consumer choice are directly relevant to value-based purchasing. We urge CMS not to "lose" measures that

impact consumer choice, even if they would not be appropriate for incorporation into the VBP payment structure, and furthermore, continue to report those measures publicly on Hospital Compare.

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 for National Health Policy of the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AARP
American Federation of State, County and Municipal Employees
Buyers Health Care Action Group
Carlson
Center for Medical Consumers
Childbirth Connection
Consumers Union
Employer Health Care Alliance Cooperative
Employer's Health Coalition
ERISA Industry Committee
Florida Health Care Coalition
General Motors
Hanover Area Health Care Alliance
Health Policy Corporation of Iowa
Iowa Health Buyers Alliance
National Business Coalition on Health
National Consumers League
National Partnership for Women & Families
National Small Business Association
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