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September 6, 2013

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

File code: **CMS-1601-P**

RE: **Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program**

Dear Ms. Tavenner:

The 29 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 2014. Our comments relate specifically to the Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) programs, as well as updates to the Hospital Value-Based Purchasing Program (HVBP).

Since the launch of the OQR program, we have applauded CMS' efforts to focus specifically on measures of safety, outcomes, and efficiency, and we are pleased to see this trend continue in the CY 2014 proposed rule. We also are pleased to see CMS's continued effort to align the OQR and ASCQR programs, which serves to drive improvement and break down the silos that exist between hospital and free-standing surgical settings. As the line between the outpatient and ambulatory surgical care settings becomes more ambiguous, it is critical that consumers who may receive care in either setting be able to access the same information on quality for both settings. Finally, we are pleased to see that the proposed measures also 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.*

However, while we support the proposed additions to both the OQR and the ASCQR, we want to call your attention to the detailed comments below reflecting our concern over the proposed removal of measure OP-19, *Transition Record with Specified Elements Received by Discharged ED Patients.* We do not agree with the rationale provided in the preamble, and urge CMS to reconsider removing this measure from the program.

We also wish to emphasize our continued frustration with the 1) measure gaps that preclude CMS from addressing variations in care in areas of importance to patients and purchasers; and 2) need for greater alignment between the public (both federal- and state-level) and private sectors' value-based efforts. On the measure development front, we urge CMS to devote resources to filling these critical gaps that prevent a comprehensive review of performance in federal programs. In addition to our comments on the measures and methodologies proposed in this rule, we also provide recommendations for measure development. Regarding alignment, we strongly encourage CMS to increase its efforts to work with

private purchasers and the states to send a strong signal to the market about the importance of improving care in priority areas. This will enable providers to focus on improvement, rather than on fulfilling multiple, disparate measurement requests, reduce the burden of data collection, and optimize the use of resources. It can only happen if CMS takes a leadership role to aggressively pursue an agenda of system-wide consistency. We look forward to working with CMS and other partners on these and related programs.

Finally, we ask CMS to implement the recommendation made in the Measure Applications Partnership's (MAP)[1] 2013 report to align measures used in the Inpatient Psychiatric Facility Quality Reporting Program and the OQR. The MAP report noted that certain psychiatric care quality measures – such as those reflecting the quality of follow-up post-hospitalization for mental illness using a tool like the Inpatient Consumer Survey (ICS) -- would be appropriate for use in the Emergency Department and should be considered for the OQR. We agree and strongly recommend that CMS pursue the addition of mental health and psychiatric care measures in the OQR program in the future.

Our detailed comments pertain to the following:

- Updates to the Hospital Outpatient Quality Reporting Program (OQR) and the Ambulatory Surgical Centers Quality Reporting Program (ASCQR)
- Updates to the Hospital Value-Based Purchasing Program Updates

OQR and ASCQR Program Updates

Proposed Measures to Be Added in CY 2016

We support the proposed addition of the five measures proposed for both programs for the CY 2016 payment year:

- Influenza Vaccination Coverage among Healthcare Personnel[2]
- Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
- Endoscopy/Poly Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients
- Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use, and
- Cataracts: Improvement in Patient's Visional Function within 90 Days Following Cataract Surgery

We believe that these five measures address important areas of concern related to public health, patient safety, health outcomes/functional status, and efficiency/overuse. All five are appropriate for collection in the outpatient setting, and all have received strong multi-stakeholder support.

Proposed Measure to be Removed in CY 2016

We also support the proposed removal of measure OP-24, *Cardiac Rehabilitation Measure: Patient Referral from an Outpatient Setting.* We opposed the implementation of this measure when it was proposed in a previous rulemaking cycle because measuring whether a referral was made by a provider to a patient is not a good indicator of care coordination. Without additional information about whether the patient actually accessed the rehabilitation services, and that the rehab facility communicated with

[1] *MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS*, Final Report, February 2013

[2] Note: this measure has already been finalized for the ASCQR for CY 2016; it is now being proposed for inclusion in the OQR for CY 2016.

the referring provider to create a care plan and helped the patient recover, this measure is not a strong indicator of care, nor would it lead to improved quality.

However, we do not support the removal of measure OP-19, *Transition Record with Specified Elements Received by Discharged ED Patients*. We have been strong proponents of this measure since its development and endorsement, and strongly supported its inclusion in the OQR. The measure is specified to quantify the number of patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:

- Summary of major procedures and tests performed during ED visit
- Principal clinical diagnosis at discharge which may include the presenting chief complaint
- Patient instructions
- Plan for follow-up care (or statement that none is required), including primary physician, other health care professional, or site designated for follow-up care
- List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each

The ED discharge process is a particularly challenging time for patients and their family/caregiver(s). A study of the experiences that patients and their caregivers have with ED care found that more than a third of the deficiencies in the experience involved a lack of understanding of post-ED discharge care. Holding outpatient settings accountable for providing the required information is a critical step to addressing this deficiency. A 2009 report by the National Transitions of Care Coalition (NTOCC) recommended that improvements in care transitions be supported by a number of actions, including "implementing payment systems that align incentives and include performance measures to encourage better transitions of care."[3] The burden felt by the hospital in having to report the data for this measure for the OQR program and to attest to providing a transition record to satisfy the MU requirements is in no way comparable to the burden patients experience if they leave the ED without a complete understanding of what the next steps are in their recovery.

Possible Hospital OQR Program Measure Topics for Future Consideration

We strongly support the clinical domains that CMS puts forth in the proposed rule for future additions to the OQR and ASCQR programs, including clinical quality, care coordination, patient safety, patient and caregiver experience, population and community health, and efficiency. Within this context, we make the following suggestions and hope CMS will take them into account in future rulemaking decisions

- **Measure patients' experience of care and require that the data be publicly 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 CMS's planned pay-for-reporting initiatives. Reports from patients about their own and their family caregiver's experiences are invaluable to understanding the effectiveness of care coordination, care transitions, and medication safety efforts. 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

[3] *Improving Transitions of Care: Emergency Department to Home,* National Transitions of Care Coalition, October 2009. http://www.ntocc.org/Portals/0/PDF/Resources/ImplementationPlan_EDToHome.pdf

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. Included in the development of a patient experience tool for the outpatient and ASC settings should be questions related to adverse events, such as medical errors and infections experienced by patients in outpatient settings. Finally, we recommend that CMS consider adding a patient-reported functional status tool, such as the VR-12, to enable a better understanding of care and functional status for patients with multiple chronic conditions.

- **Measure of Central-Line Associated Blood Stream Infection (CLABSI).** We applaud the finalization of the surgical site infection measure in the CY 2012 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 or a serious hospital-acquired infection composite measure 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.

- **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, 2012, and 2013 OPPS 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 that 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 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 is the top priority for measure development and implementation of a National Quality Forum advisory committee seeking consensus around prioritization for the Medicare population. Thus, we recommend implementing the PHQ-9, which screens for depression and assesses functional status, to the OQR. It is widely used in the public (nursing home payment) and private (ACOs, regional collaboratives) sectors—an excellent opportunity to ensure cross-sector alignment.

- 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 useful source 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.

Updates to the Hospital Value-Based Purchasing Program
CMS is proposing the following time periods for data collection for hospital performance on rates of CAUTI, CLABSI and SSI:

- Baseline: January 1, 2012 - December 31, 2012
- Performance: January 1, 2014 – December 31, 2014

We believe these time periods are appropriate and make more sense than the 11 month performance period originally created in the FY 2013 IPPS Final Rule.

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
The Alliance
American Benefits Council
American Federation of State, County & Municipal Employees
American Hospice Foundation
Business Healthcare Group
Caregiver Action Network
Center for Medical Consumers
Childbirth Connection
Consumers Union
Dallas-Fort Worth Business Group on Health

Equity Healthcare
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
Massachusetts Group Insurance Commission
Mothers Against Medical Error
National Business Coalition on Health
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