

September 2, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW
Room 445-G
Washington, DC 20201

RE: CMS-1404-P; Proposed Changes to Hospital Outpatient Prospective Payment System

Dear Mr. Weems:

As you know, the Hospital Quality Alliance (HQA) is committed to making meaningful, relevant and easily understood information about hospital performance available to the public and to informing and encouraging efforts to improve quality. On behalf of the undersigned members of the HQA, we offer the following overarching comments as well as specific feedback on the proposed changes to the hospital Outpatient Prospective Payment System that are detailed in CMS-1404-P.

Overarching Comments

- Outpatient performance information should be posted in 2010 on the Hospital Compare website.
- Changes to the website's architecture, navigation, display and language should be thoroughly tested with consumers to determine the most useful way to integrate the information into Hospital Compare.
- Measures that assess provider "efficiency" will portray a new aspect of quality, therefore we urge CMS to communicate this information in a manner that clearly interprets the differences between providers, i.e., whether higher quality is associated with a higher or lower efficiency score, whether there is an appropriate rate or benchmark, and how should consumers integrate this information into their decision making.
- Creating clear and explicit definitions for the outpatient setting (e.g., (1) clinic – free-standing or hospital-based; (2) ambulatory surgery center – free-standing or hospital-based; and (3) primary care settings) would benefit the field by providing greater clarity regarding what is in and out of a measure's scope.
- As claims-based measures are being used for both the inpatient and outpatient settings, we want to reiterate that we:
 - Support the use of all (or multiple) payer data when possible as it provides a more complete picture of care.
 - Support CMS in its efforts to leverage data collected by third parties, e.g., state data organization, state hospital association, registries, or AHRQ. To that end, states could either transmit patient de-identified claims (protecting patient privacy) to CMS/third party or calculate the performance measures and send the results to CMS for public reporting. Either option would require states to expend resources; therefore we recommend that a consistent and fair method be used to compensate them for their efforts.
 - Encourage CMS to be able to ensure the validity of third-party data.

Proposed Measures for CY2010

For CY2010, CMS proposed to require the continued submission of data on the existing seven outpatient measures and adopt five additional imaging efficiency measures. Of these five measures, only two – MRI Lumbar Spine for Low Back Pain and Use of Contrast for Thorax CT – are being recommended for endorsement by the NQF Outpatient Imaging Efficiency Steering Committee.

We feel that it is important to note that in order for stakeholders to adequately and thoroughly comment via rulemaking, CMS must ensure that detailed information is publicly available about quality measures, e.g., measure specifications, the measures' initial performance in the field, and the results of the testing. Because these measures were not available to the public at the time the rule was released, it impeded stakeholders' ability to thoroughly and completely evaluate their strengths and weaknesses.

Using the information we had available to us, we offer the following comments:

1. (OP-8) MRI Lumbar Spine for Low Back Pain
 - While there is some concern about the ability for claims data to adequately capture the necessary performance information, we recognize that the information needed for this measure is not available via chart abstraction so are generally supportive of this measure being implemented.
 - We applaud the fact that this measure is harmonized with NCQA low back pain measure.
 - The measure would be improved if all-payer (or multi-payer) data could be utilized.
 - The measure assesses the utilization of imaging services by the rendering facility but reflects care provided across several health care settings. It is unknown to what extent hospitals have influence over the ordering practices of community physicians. Hospitals are also unlikely to have access to patients' community-based physician medical records to know what diagnostic tests or treatments patients have received prior to arrival at the hospital for an MRI.
 - It will be important to clearly communicate what the measure portrays and whether better quality is indicated by a higher or lower efficiency score and whether there is an appropriate rate or benchmark.
2. (OP-9) Screening Mammography Follow Up Rates
 - Breast cancer and preventative screening is a worthy topic area and we applaud CMS for developing measures that address this condition; however as currently constructed the measure suffers from some significant flaws. The appropriate rate for follow-up is unknown and would vary significantly given the ultimate results of the test or diagnosis. Given that some facilities see patients at higher risk than others, risk-adjustment or further stratification by risk factors would be needed to provide an apples-to-apples comparison of provider performance.
 - It is our understanding that this measure is not being recommended for endorsement by the NQF Outpatient Imaging Efficiency Steering Committee.
3. (OP-10a) Use of Contrast: Abdomen CT – Excludes Nephrology
4. (OP-10b) Use of Contrast: Abdomen CT - Nephrology Only
 - It is our understanding that this measure is not being recommended for endorsement by the NQF Outpatient Imaging Efficiency Steering Committee.

5. (OP-11) Use of Contrast: Thorax CT

- Given that the contrast material should be used the first time a patient undergoes a thorax CT, we feel that the measure appropriately assess for the following: (1) the underuse of contrast; (2) the degree to which patients' time is wasted returning for a second CT test if contrast was not used initially; and (3) the degree to which patients are unnecessarily exposed to a second dose of radiation.
- It will be important to clearly communicate whether better quality is indicated by a higher or lower efficiency score and whether there is an appropriate rate or benchmark.

Proposed Process for Updating Measures

We appreciate and support the need for flexibility to make small changes, e.g., antibiotic administration within 6 hours – not four hours – of hospital arrival, via a sub-regulatory process by providing a minimum 3 month notice on QNet. However, we ask that CMS develop criteria that would delineate the characteristics of a “small technical” change as opposed to one that is “material or substantive” which should require vetting through the federal rulemaking process. In particular, the National Quality Forum’s Measure Maintenance Proposal may be informative (<http://www.qualityforum.org/pdf/Measure%20Maintenance%20ProposalFinal.pdf>).

Potential outpatient measures for CY 2011

We ask that CMS consider the following issues in regard to future outpatient measures:

- How do these measures intersect with any relevant AQA-adopted physician measures?
- To what extent have these measures been fully tested in a variety of outpatient settings? Have the testing sites been varied enough to accumulate a good understanding of the challenges or opportunities for improvement? Sites should vary by: (1) size, volume of services; (2) level of care provided and type of care; (3) location and diversity across regions; (3) type of hospital (community, academic medical center, etc.); and (4) EHR implemented.
- Some measures (e.g., cancer) were created using registry data; will the measures be specified and tested for alternate data sources (claims or chart review)?
- Have the measures that relate to one another been evaluated for how well the data elements, definitions, and allowable values are harmonized, i.e., same condition in a different setting or the same setting but multiple conditions?

In addition, the alignment of measures across settings is a worthy goal, therefore, where there is good evidence that outcomes can be positively influenced; CMS should select measures for the Hospital Outpatient Program (HOP) from the current inpatient measures.

Data Collection & Submission Requirements

CMS proposes that hospitals collect data using a sampling methodology so that it will not be necessary to submit data for all eligible cases if a sufficient threshold is met. Further, hospitals that have five or fewer claims (both Medicare and non-Medicare) for any measure in a quarter would not be required to submit patient level data for the entire measure topic for that quarter. The hospital would still be required to submit its aggregate measure population and sample size counts for the applicable measure topic as part of its quarterly data submission. We would like to clarify that this sampling methodology relates only to chart-based measures and not the proposed imaging efficiency measures as those are derived from claims data. In general, we support the efforts to reduce the burden related to data collection and submission.

Validation Requirements

CMS proposes to randomly select per year 50 patient episodes of care that a hospital successfully submitted to the OPSS clinical warehouse. These data will be validated using the medical record documentation by a CMS contractor who will independently re-abstract quality measure data from those records and calculate the percent agreement for each measure, rather than the match rate of individual data elements. Data will be validated from 800 randomly selected hospitals (approximately 20 percent). We support this approach and believe it will produce a more reliable estimate of whether that hospital's data has been submitted accurately.

Publication of Hospital Outpatient Program Data

We want to reiterate our early comments that hospital outpatient performance data should be published on the Hospital Compare website with the appropriate consumer testing. The imaging efficiency measures present a unique opportunity to test the concept of overuse versus underuse with consumers. Doing robust consumer testing may yield valuable insights into this new concept of "efficiency" which differs from the domain of clinical quality that has historically been the focus of Hospital Compare.

CMS also proposed to indicate on Hospital Compare when performance measures combine results from two or more hospitals. Approximately 5 to 10 percent of hospitals share the same CMS Certification Number (CCN). We strongly encourage CMS to report performance information at an individual hospital level and urge that addressing this problem be a high priority. CMS could consider adding an identifier (e.g, 1, 2, 3, etc.) to the CCN in order to differentiate individual hospitals that share a single number.

We support replacing the paper Notice of Participation form and with online registration so that hospitals can more easily agree to allow CMS to publicly report the quality measures.

Reporting Ambulatory Surgery Center Quality Data for Annual Payment Update

The Secretary has the authority to require Ambulatory Surgery Centers (ASC) to submit data on quality measures and reduce the annual payment update by 2.0 percentage points for ASCs that fail to do so. CMS delayed in implementing provisions because the transition to the revised payment system in 2008 posed such a significant challenge to ASCs that it would be appropriate to allow some experience with the revised payment system prior to introducing other new requirements. CMS continues to have the same concerns and will defer the reporting of quality data for ASCs until future rulemaking.

We encourage CMS to move forward with reporting ASC quality data as soon as possible and suggest CMS build upon states' existing efforts to collect data about ASC performance. According to a survey conducted by the National Association of Health Data Organizations (NAHDO), more than 35 states are currently collecting and using ASC data.

Healthcare Associated Conditions

In the proposed rule, CMS suggests that the non-payment policy for certain healthcare associated conditions could be applied beyond the inpatient setting to the outpatient setting, ambulatory surgery centers, etc. It is our understanding that if CMS were to more broadly apply this policy, it would require statutory authority granted by Congress similar to what it was given by the Deficit Reduction Act.

As CMS is in the process of implementing the hospital-acquired conditions' payment provisions in the inpatient setting, this presents an opportunity for CMS to collaborate with and receive input from relevant stakeholders to examine the impact and effects of the program. Understanding and learning from the experience in the inpatient setting is an important and critical step that should occur before expanding into the outpatient setting.

Again, thank you for the opportunity to comment. The HQA looks forward to continuing to work with you to advance the quality and transparency of hospital care. Should you have any questions, please contact Katherine Browne at kbrowne@hospitalqualityalliance.org or 202-828-0549.

Sincerely,