

# Consumer-Purchaser

## DISCLOSURE

### PROJECT Improving Health Care Quality through Public Reporting of Performance

June 30, 2009

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

**File Code: CMS-1406-P (Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2010 Rates)**

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

Dear Ms. Frizzera:

The 23 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, to the Reporting of Hospital Quality Data for Annual Hospital Payment Update (RHQDAPU) program for Fiscal Year 2010. As we have since the RHQDAPU program began, we commend the efforts Centers for Medicare and Medicaid Services (CMS) to foster increased transparency and promote a market that recognizes and rewards quality. The health care reform debate currently taking place has put a laser focus on the need to pay health care providers based on value, rather than on volume; continuing to refine the RHQDAPU program is one way that CMS can play an important role in advancing the effort to bring quality and value into public reporting and reimbursement strategies.

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 incentives that can spur changes and foster a health care system that:

- Improves clinical quality by addressing problems of underuse, overuse, and misuse of services;
- Encourages patient-centered care, patient engagement, and shared decision-making;
- Encourages care coordination and supports the integration and delivery of services across providers and care settings, particularly for the frail elderly and 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, particularly through health information technology;
- Reduces disparities in health care and encourages the provision of quality care for at-risk populations in a culturally competent manner; and
- Provides meaningful performance information to consumers, providers, and others.

Our comments all pertain to issues raised in the section of the proposed rule pertaining to hospital quality data reporting.

## **Section II. F: Preventable Hospital-Acquired Conditions (HACs) Including Infections**

Following a listening session held by CMS on December 18, 2009, the Consumer-Purchaser Disclosure Project submitted a list of candidate healthcare-acquired conditions (HACs) for the agency to consider in developing the FY 2011 IPPS Proposed Rule. As noted in that letter, consumers and purchasers believe that non-payment for HACs in the inpatient arena is a payment strategy that is directly aligned with many of the priorities identified by the National Priorities Partnership, convened by the National Quality Forum, including patient safety, care coordination, and overuse. We commend CMS for acknowledging the need to evaluate the HAC payment provision based on early experience. Results of this evaluation will better inform the field and CMS in general on the strategy of non-payment for healthcare-acquired conditions. However, in the interim, we believe it is appropriate for CMS to add the following conditions to the program based on the volume at which they occur, and their correlation with poor outcomes, higher costs, and preventability:

- *Ventilator-Associated Pneumonia*: This was a candidate measure in the FY 2009 IPPS Proposed Rule, and we were disappointed that it was not included in the final rule. Complications due to VAP are serious, relatively frequent, and add significantly to the cost of care. While the evidence is mixed on whether VAP is 100 percent preventable, there is no doubt that it is largely preventable. New research indicates that body position (flat vs. semi-recumbent) can have a significant effect on frequency and rates.<sup>1</sup> As we strive to meet the National Priorities Partnership goals under the *Patient Safety* priority area, we support the inclusion of VAP's in the RHQDAPU program to encourage providers to work toward zero occurrence.
- *Surgical Site Infection Following Device Procedure*: Adding "surgical site infection following device procedure" is a logical next step beyond the other surgical site infection HACs already implemented in the IPPS.
- *Failure to Rescue*: This AHRQ Patient Safety Indicator is an important measure of quality and safety of hospital care and should be included with the application of the exclusion for patients who have documented Do Not Resuscitate (DNR) orders in place. There are several National Quality Forum "never events" measures that are not included among the HACs for non-payment. While our recommendation to expand the list of measures does not include all such indicators we do support including those for which non-payment will a) improve patient safety and outcomes; and b) will not hamper an evaluation of the program or create undue burden on hospitals and providers.

## **Section IV. V/A: Reporting of Hospital Quality Data for Annual Hospital Payment Update**

**General Comments on the RHQDAPU Program:** The inpatient pay-for-reporting program already has more than the minimum number of measures mandated by the Deficit Reduction Act of 2005. But, as is true in health care reimbursement itself, volume does not necessarily equate to quality. Even with forty-eight pay-for-reporting measures, there continue to be significant gaps in care where performance assessment and reporting would help to stimulate improvement. For example, there are no measures for hospital acquired infections, and there continue to be measurement gaps in broader areas, such as resource use and efficiency; discharge planning and care coordination; and outcomes such as functional status and quality of life. Now that the hospital inpatient measurement and

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<sup>1</sup> Drakulovic et al., Lancet 1999; 354: 1851 – 58.

reporting system has been in place since FY 2004, we feel it is time to step back, consider the portfolio of measures on which hospitals have to report, and think about where to focus future efforts.

Such a strategic review would be in line with the roadmaps that CMS disseminated earlier this year on the subjects of quality measurement, resource utilization, and value-based purchasing, as well as with the goals identified by the National Priorities Partnership. Determining which measures to add or keep in the pay-for-reporting program should also align with legislation directing Medicare to pursue hospital value-based purchasing. As legislative efforts continue in this arena, we urge CMS to be forward-thinking and continue to take a leadership role, choosing measures that can be the basis of potential payment reform.

In this context, we think that CMS should provide its rationale for deferring some measures from 2011 to 2012. There are many measures in the proposed 2012 new measure set that impose no burden on hospitals -- i.e., the data for the measures are obtained from administrative data -- and/or address important new conditions, (e.g. stroke), procedures, (e.g. PCI), and/or represent significant advances in outcomes reporting. If the reason for delay is burden of reporting, consideration should be given to retiring measures in 2011 that are lower priority than the proposed new measures. For example, reports from the field indicate that the condition-specific adult smoking cessation advice/counseling measures have not accomplished their intended purpose. Hospitals have largely treated these measures as a check-off item that simply indicates whether the provider believes the requisite counseling has been offered, not whether patients understand the advice and counseling that has purportedly been given. We strongly urge CMS to replace the condition-specific counseling measures with a global smoking cessation advice/counseling measure that can be obtained via the HCAHPS survey from an adequate sample of all hospitalized patients.

**Measures Considered for FY 2011:** We strongly support public reporting of information that will improve care, increase patient safety, and foster high performance within the health care system. CMS showed its desire to advance those goals by adopting 15 additional measures for payment determination in the FY 2009 IPPS final rule, bringing the total number of measures in the RHQDAPU program to 44. For the reasons explained below, we support the four measures (listed in Table 1 below) that CMS has proposed adding to the program for FY 2011:

<b>Table 1. Proposed <i>Additional</i> RHQDAPU Program Quality Measures for FY 2011 Payment Determination</b>	
<i>Chart Abstracted measures</i>	<ul style="list-style-type: none"> <li>• SCIP-Infection-9: Postoperative Urinary Catheter Removal on Post-Operative Day 1 or 2</li> <li>• SCIP-Infection-10: Perioperative Temperature Management</li> </ul>
<i>Structural Measures</i>	<ul style="list-style-type: none"> <li>• Participation in a Systematic Clinical Database Registry for Stroke Care</li> <li>• Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care</li> </ul>

We are in favor of the two additional SCIP measures based on their potential to make a significant impact on patient safety. If these two measures are adopted, there will be 10 SCIP measures in the RHQDAPU program.

In terms of public reporting groups of measures, like the 10 SCIP measures, on *Hospital Compare*, consumers want information that will help them know if they will get good care at a particular hospital. In order to reach this public reporting goal, we urge CMS to continue to test reporting formats and explanation of the measures to be sure that patients correctly interpret the information that is published (see “public display of quality measures” below for more detail on this point).

Regarding the two registry measures, we believe that the ability to use registries to obtain data can be a critical component of both fostering true “meaningful use” of interoperable HIT, as well as supporting comparative effectiveness research (CER) that can inform improvements in care coordination, reducing overuse, and achieving better outcomes. Registries can also play a crucial role in evaluating functional status, as well as other difficult-to-measure areas.

While we do support the four measures proposed for FY 2011, we are concerned with the lack of hospital resource use and efficiency measures in the proposed measure set. Costs of overuse or the provision of low value services in Medicare (as well as the rest of the health care system) exacerbate the issue of affordability for all consumers and purchasers and should be spotlighted in measures that are collected and publicly reported to call attention to the need for efficient resource use.

**Possible Measures for FY 2012:** In the context of the need for CMS to strategically add measures, we provide the following comments on the extensive list of quality measures that are presented for possible use in FY 2012. We support many of the measures proposed because they represent progress toward the goal of hospital reporting on outcomes, such as the AHRQ-PSI and IQI measures that focus on outcomes for a broad number of conditions and procedures, as well as additional readmissions and mortality measures. We also support the nursing sensitive measures for their focus on patient safety and workforce stability. In addition, we are in favor of including measures related to MRSA and Clostridium Difficile Associated Diseases. We acknowledge that currently there are gaps, both in endorsed measures, as well as in agreed-upon interventions, to address these particular healthcare-acquired conditions. However, both conditions are enormous population health and patient safety concerns which should be reflected by the RHQDAPU program. While the categories of Stroke, VTE, and Cardiac Surgery are obviously extremely important, we feel that the measures listed as possible for 2012 are more process than outcome oriented, and may add only marginal benefit. We suggest CMS consider VTE, stroke, and cardiac surgery measures that directly relate to outcomes and resource use in preparing next year’s proposed rule.

### **Measure Retirement, Harmonization, and Public Reporting**

**Retirement of the AMI-6 measure:** We support retirement of this measure (beta blocker upon arrival). As noted in the proposed rule, data collected since the implementation of this measure have shown that there is enough evidence of its unintended negative consequences for certain patient populations to make it inadvisable for global use. We agree that it is important that CMS have a policy in place to respond to real-world experience and to keep the RHQDAPU program aligned with current evidence and research.

**Measure Harmonization Activity:** We support the harmonization of the two measures: PSI-04 (Death Among Surgical Patients with Treatable Serious Complications) and the Nursing Sensitive Measure “Failure to Rescue.” These two measures have been harmonized within the NQF portfolio, so this would result in RHQDAPU being aligned with currently accepted practice.

**Public Display of Quality Measures:** There is very little language in the proposed rule regarding public display of quality measures on *Hospital Compare*. As noted above, we continue to urge CMS to display data on Hospital Compare in a way that enables consumers to use this website as a decision-support tool and to be mindful of the range of decision making and health literacy skills within the general population, including older persons. Refining the overall “map” of *Hospital*

*Compare* to make it easier to find information is one strategy. Another would be developing composite measures that summarize quality in specific measurement areas. It is important that the method selected to aggregate the components of a composite, including the weights, result in a fair and accurate characterization of performance. In addition, we applaud recent efforts by CMS to rectify the Hospital Compare data display to indicate where hospitals had too few data points to be listed in the ratings for certain measures. While the lack of information remains a concern, at least in these cases the hospitals with too few cases are not being included in a broader category of “below” or “above” average. As in the comments made by many of the undersigned groups to the IPPS Proposed Rules last year, we recommend testing other data display techniques (using deciles, etc.) to show variation in quality, as well as the inclusion of Medicare beneficiaries in determining what level of confidence is appropriate for their decision-making in cases where performance strata depend on statistical confidence intervals. While only four measures are being proposed for addition this year, the number may increase (particularly in light of the measures being considered for FY 2012); thus it will become increasingly important to consider all the issues around public display of data if CMS wants Hospital Compare to be a source of useful information for consumers.

We also continue to urge, that for purposes of reporting data on *Hospital Compare*, CMS require that hospitals with multiple campuses be provided distinct CMS Certification Numbers (CCN) for each campus, rather than combining data from multiple campuses that share a CCN. The current practice of combining these data does 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 encourage 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.

### **Electronic Health Records**

**Data Collection:** We noted in our comments last year on the FY 2009 Proposed Rule that CMS’ broadening of the list of measures for pay-for reporting should spur hospitals to invest in electronic information systems that support quality measurement and improvement. Thus, we are pleased to see CMS taking the lead by entering into an inter-agency agreement with the Office of the National Coordinator for Healthcare Information Technology (ONC) to harmonize standards for EHR-based submissions of emergency department, stroke, and venous thromboembolism measures. As the quality measurement enterprise continues to strive to make data collection less burdensome for doctors and institutions, the need for close collaboration among CMS, ONC, HIT systems vendors, and other stakeholders will only grow.

As part of this work, we strongly suggest that CMS acknowledge opportunities for developing EHRs with capability to collect administrative data related to RHQDAPU measures. For example, “Left Ventricular Function” is a key variable in CABG and Valve Repair cases; adding this one variable would allow stakeholders to look at CABG performance in the administrative data rather than solely through more burdensome-to-obtain clinical data. Other variables that can be gleaned from an EHR and added to claims files include electronic laboratory values and pharmacy information. Together, these would create a more robust administrative data system, which would be particularly useful for looking at resource utilization and efficiency.

**ICD-10 Implementation:** While we applaud CMS working collaboratively with ONC, we are concerned about the lack of language in the proposed rule regarding how the implementation of the ICD-10 data coding system will be synchronized with these EHR certification efforts. Given that ICD-10 is scheduled to be in place by 2015, we urge CMS to put language in the final rule emphasizing the need for ensuring that the ICD-10 implementation effort is harmonized with standards promulgated for EHR vendors.

**Data Submission Testing:** With regard to data submission testing, CMS notes that it will use similar processes and procedures to those used for the PQRI EHR testing, and will expect EHR vendors to employ mechanisms and formats that aid the submission process when interoperable standards become available. We encourage CMS to develop technical assistance modules, as well as a plan or program for disseminating them, to make sure that the investment in interoperability standards is not lost at the point of implementation. One possible way of disseminating technical assistance is to consider additional funding for the regional centers that are being supported by the American Reinvestment and Recovery Act (ARRA) to work with hospitals and coordinate efforts between CMS, EHR vendors, and hospital data collection staff.

Finally, we again urge CMS to look at the current investments being made in HIT through ARRA as an opportunity to advance electronic reporting and define a clear timeframe for making this the standard for data collection. The final IPPS rule should include language that sets a period of time (e.g. three years) after which any measure must be collected as part of the standard process of delivering care and be submitted electronically. We believe electronic information can be an efficient solution for supporting an effective quality improvement environment within a hospital. Hospitals cannot improve what they cannot track.

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

Sincerely,

AARP  
American Benefits Council  
American Hospice Foundation  
Bridges to Excellence  
Business Health Care Group of Southeast Wisconsin  
Buyers' Health Care Action Group  
Center for Healthcare Improvement  
Childbirth Connection  
Consumers Union  
Employers Health Purchasing Corporation of Ohio  
Group Insurance Commission of Massachusetts  
Health Policy Corporation of Iowa  
Healthcare 21 Business Coalition  
HR Policy Association  
Iowa Health Buyers Alliance  
Mid-Atlantic Business Group on Health  
National Business Coalition on Health  
National Partnership for Women & Families  
New Jersey Health Care Quality Institute  
Pacific Business Group on Health  
Service Employees International Union  
The Alliance  
The Leapfrog Group