MEDPAC Medicare Payment Advisory Commission

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August 30, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1504-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: File code CMS-1504-P

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit comments on CMS's proposed rule entitled: *Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs; and Proposed Changes to Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations* [CMS-1504-P]. We appreciate your staff's ongoing efforts to administer and improve the payment system for hospital outpatient departments and ambulatory surgical centers, particularly considering the agency's competing demands.

As you know, the outpatient prospective payment system (OPPS) classifies services provided in outpatient departments into ambulatory payment classification (APC) groups. Each APC group has a relative weight, which is an indexed measure of the resources needed to furnish a service. The OPPS determines payment rates for APC groups as the product of the relative weights and a conversion factor. This proposed rule is similar to its predecessors in the sense that it documents changes in the composition of some APC groups and proposes changes to the relative weights based on analysis of claims and cost report data. The rule also estimates the calendar year 2011 update to the conversion factor.

This rule also proposes to:

- Provide substantial proportional increases to the payment rates for OPPS covered services provided by the 11 cancer specialty hospitals.
- Repeat the policy established in 2010 of redistributing estimated pharmacy overhead costs from drugs that are packaged with an associated procedure to drugs that are paid

separately. The intent of this policy is to improve how accurately payments for separately paid drugs reflect the hospitals' costs of acquiring and handling them.

- Modify the criteria that hospitals must meet in regard to physician supervision of therapeutic services provided in hospital outpatient departments.
- Add several quality measures for payment determination in 2012, 2013, and 2014 under the hospital outpatient quality data reporting program (HOP QDRP). Hospitals that do not fully comply with the requirements of the HOP QDRP have all payments under the OPPS reduced by 2 percent.
- Defer the reporting of quality data by ASCs for at least one additional year.

We focus our comments on these 5 topics.

Increase payment rates for cancer hospitals above payment rates for other hospitals

There are 11 hospitals classified as cancer hospitals under section 1886(d)(1)(B)(v) of the Social Security Act. The Patient Protection and Affordable Care Act of 2010 (PPACA) directs the Secretary to determine whether the costs incurred by cancer hospitals under the OPPS exceed those incurred by other hospitals. If the Secretary finds that cancer hospitals incur higher costs, the Secretary shall adjust payments to cancer hospitals to reflect these higher costs.

CMS' method in this study was straightforward. The agency compared simple means of costs and other variables that affect costs for two hospital groups: Cancer hospitals and all other hospitals. From this analysis, CMS emphasized two findings: all cancer hospitals have lower payment-to-cost ratios (PCRs, a measure of a hospital's profit margin) than the average PCR for all other hospitals and cancer hospitals have much higher cost per unit than other hospitals (adjusted for service-mix complexity).

Based on these results, CMS has proposed to make proportional adjustments to the OPPS payment rates of cancer hospitals to levels much higher than the rates for all other hospitals. The goal of these adjustments is to increase the PCR for each cancer hospital to the average PCR for all other hospitals (estimated to be .868). Therefore, the adjustments would be hospital specific and would depend on the current PCR of each cancer hospital. The adjustments received by cancer hospitals will be inversely related to their PCRs. The PCRs for cancer hospitals appear to vary widely, because the proposed proportional adjustments are as low as 5.9 percent for one cancer hospital and as high as 82.6 percent for another one. In aggregate, this policy would increase OPPS payments to cancer hospitals by 41.2 percent. In addition, cancer hospitals would still be eligible for hold-harmless payments and outlier payments.[a] However, hold-harmless payments would be

[a] To determine a hospital's hold-harmless payments, CMS first estimates for a given year the payments the hospital would have received under the cost-based payment system that preceded the OPPS. Qualifying hospitals receive the greater of the estimated payments from the cost-based system or the actual OPPS payments. Hospitals that currently qualify for hold-harmless payments include cancer hospitals, children's hospitals, sole-community hospitals (SCHs), and other rural hospitals with 100 or fewer beds. However, SCHs and other small rural hospitals will no longer be eligible after December 31, 2010, while cancer hospitals and children's hospitals have permanent eligibility.

much lower than current levels because they would be determined after the application of this proposed adjustment to the base payment rates.

We recognize that CMS is required by law to undertake this study and is also required to adjust OPPS payments to cancer hospitals based on the results of this study. However, we are concerned that the law overlooks important issues that we express here:

- The PPACA had only one criterion for being included in this study: being one of these 11 cancer hospitals. The Commission is unclear how the targeting of this policy was determined by law. Many hospitals have large populations of cancer patients but are not counted as one of these 11 hospitals. If there is something unique about the costs of cancer patients, then the universe of hospitals providing cancer care should be studied before an adjustment is made to payments. By focusing only on these 11 cancer hospitals, this study may be identifying the high-cost characteristics of these 11 cancer hospitals rather than the unique costs of treating cancer patients.
- CMS had to use the cancer hospitals' costs as given, and we believe that consideration should be given to whether a hospital has been attentive to keeping its costs down. If adjustments are made, perhaps they could be mitigated for hospitals found to have costs that are high relative to their peers. The hold-harmless payments these hospitals receive are particularly relevant because these payments are based directly on a hospital's costs. The higher a hospital's costs, the greater its hold-harmless payments. We believe that being eligible for hold-harmless payments could reduce a hospital's incentive to hold down costs.
- The PPACA does not require that CMS make these additional payments to cancer hospitals dependent on the quality of care. However, we believe that additional payments should be guided to some extent by the quality of care provided. The PPACA requires the 11 cancer hospitals to begin submitting quality data in fiscal year 2014. Consequently, we believe it would be prudent to delay additional payments to cancer hospitals until these quality data are available to serve as a basis for payment.
- These additional payments to cancer hospitals must be budget neutral to the Medicare program, which means that OPPS payments to all other hospitals must be reduced. This raises an issue of equity, as we estimate that these additional payments will amount to $300 million for cancer hospitals, which must be paid through lower payment rates to all other hospitals.

Pharmacy overhead costs and setting payments for separately paid drugs

In the OPPS, CMS provides separate payment for drugs whose costs exceed a set threshold. For 2011, CMS has proposed to set this threshold at $70 per day. For drugs whose costs do not exceed this threshold, CMS packages their costs into the payment rate of the applicable outpatient service.

From 2006 through 2009, CMS determined the payment rates for separately paid drugs using drug charges from claims then estimating a cost for each drug by multiplying the drug charges by the cost-to-charge ratio (CCR) from the cost center for drugs on the hospitals' cost reports. CMS compared the average of these estimated costs across all separately paid drugs to the average of the average sales price (ASP) for these drugs. CMS has based the payment rates for separately paid

drugs on this comparison, resulting in payments for separately paid drugs that are a percentage of each drug's ASP. For example, the payment rate in 2009 for each separately paid drug was 104 percent of the drug's ASP. We will refer to this method of ratesetting as the "standard method." The payment rates that result from the standard method are intended to cover the acquisition costs and the pharmacy overhead costs hospitals incur for separately paid drugs.

A group of industry stakeholders—some cancer hospitals, some pharmaceutical manufacturers, and some hospital and professional associations—argued the standard method produces payment rates that are below cost for separately paid drugs. The cause of the underpayment is CMS's use of the same CCR to estimate the cost of all drugs furnished by a hospital. Hospitals have stated that they tend to mark-up charges for low-cost drugs (which tend to packaged) by a greater proportion than they mark-up high-cost drugs (which tend to be separately paid). This results in costs being overestimated for low-cost drugs and underestimated for high-cost drugs, an effect termed "charge compression." An artifact of this cost estimation method is that it redistributes the estimated pharmacy overhead costs from high-cost, separately paid drugs to low-cost, packaged drugs.

CMS developed a method for redistributing pharmacy overhead costs from packaged drugs to separately paid drugs as part of the method for setting rates in 2010 for separately paid drugs. Based on this method, CMS decided for 2010 to redistribute $200 million from the pharmacy overhead costs of packaged drugs to the pharmacy overhead costs of separately paid drugs. For 2011, CMS has proposed to repeat the 2010 policy of redistributing $200 million of pharmacy overhead costs from packaged drugs to separately paid drugs. This would result in payments rates for separately paid drugs of ASP+6 percent.

An objection we have to setting payments as a percentage of ASP is that it implicitly assumes that pharmacy overhead costs are the same proportion of total costs for all drugs. However, we show in our June 2005 Report to the Congress that pharmacy overhead costs as a percentage of total costs vary widely across drugs. Consequently, as an alternative method for accurately paying for drugs, MedPAC has recommended that CMS collect data on hospitals' pharmacy overhead costs separately from drug acquisition costs. These data could be used to create separate payments to hospitals for pharmacy overhead and drug acquisition costs. In a previous rule, CMS rejected this recommendation, arguing that it would reduce the amount of packaging in the OPPS, which CMS has been trying to increase in recent years.

CMS has also considered a recommendation from the APC panel that CMS should exclude from its ratesetting calculations data from hospitals that participate in the 340B federal drug pricing program. The 340B hospitals are generally hospitals that serve a disproportionate share of low-income patients and receive disproportionate share payments under the inpatient PPS. These hospitals may acquire outpatient drugs and biologicals at prices that are substantially below ASP. The panel's concern is that use of charge data from 340B hospitals in the ratesetting method results in estimated costs for separately paid drugs that are below the costs incurred by non-340B hospitals.

CMS rejected this recommendation for 2010 and proposed to reject in again for 2011. Implementing this recommendation would increase payment rates for separately paid drugs. To maintain budget neutrality in the OPPS, CMS would have to reduce payment rates for all other services in the OPPS. These adjustments would result in payments being redistributed to separately paid drugs from other services. CMS does not believe this redistribution would be appropriate.

We encourage CMS to reconsider its proposal to reject the recommendation from the APC panel to exclude data from 340B hospitals from the ratesetting. Analysis by Direct Research LLP indicates that exclusion of the 340B hospitals would increase CMS's estimates of the cost of separately paid drugs by about 3.5 percent above the estimate obtained when the 340B hospitals are included in the ratesetting. We believe the effect of whether the 340B hospitals are included in the ratesetting is not trivial and excluding the 340B hospitals would result in payment rates for separately paid drugs that more accurately reflect the costs incurred by other hospitals.

Requirements for physician supervision of therapeutic services

In the 2010 OPPS final rule, CMS adopted policies regarding physician supervision of therapeutic services provided in hospital outpatient departments. CMS's policy required direct supervision of therapeutic services. Direct supervision means that the supervisory physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure. CMS emphasizes that direct supervision does not require the physician or nonphysician practitioner to be in the room when the procedure is performed.

When CMS implemented this policy in January 2010, the agency began receiving feedback from critical access hospitals (CAHs), other rural hospitals, and their representatives. For example, the CAHs noted that CMS's policy regarding physician supervision of therapeutic services is stricter than the requirements they face under the CAH conditions of participation (CoPs). Under the CoPs, CAHs must have a physician or one of several types of nonphysician practitioners available by phone at all times, but they are not required to be on the hospital's campus. Both CAHs and rural hospitals have indicated that a shortage of qualified practitioners in rural areas makes it difficult to staff a physician or nonphysician practitioner for direct supervision purposes.

In this rule, CMS has proposed a modest change to the supervision policy for therapeutic services in hospital outpatient settings. This change would apply to all hospitals, including CAHs. The proposed change is that for a specified group of services, there would be a requirement for direct supervision of the initiation of the service followed by general supervision for the remainder of the service. General supervision is not as strict as direct supervision and is defined as a service being under the overall direction and control of a physician, but his or her physical presence is not required during the performance of the procedure.

These changes would apply to a limited set of services with a significant monitoring component that can extend for a sizable period of time, that are not surgical, and that typically have a low risk of complication after assessment at the beginning of the service. As part of the process of identifying which services to include under this policy, CMS considered the concerns of CAHs

and rural hospitals that any service with an extended duration and a significant monitoring component could challenge a hospital's ability to ensure direct supervision. CMS used the following criteria to identify which services to include:

- The service be of extended duration, frequently extending beyond normal business hours,
- The service largely consists of a significant monitoring component typically conducted by nursing or other auxiliary staff,
- The service is of low enough risk that it typically would not require direct supervision often during the service, which we assume to mean that events requiring direct supervision are rare and not life threatening,
- The service is not a surgical service.

CMS has proposed 13 services to include in this policy, as defined by HCPCS codes. The general categories of these services include observation care, intravenous infusion, subcutaneous infusion, and therapeutic, prophylactic, or diagnostic injections.

We support the general concept of modifying the requirements of physician supervision of some therapeutic services provided in hospital outpatient departments. However, we encourage CMS to consult with independent experts to verify that these modifications will not compromise patient safety.

In this rule, CMS also proposed that outpatient care provided in CAHs would be subject to the same supervision requirements as in all other hospitals. We support this proposal as well, as we believe it will help assure quality of care. However, over time CMS should align the CoPs with regulations set in rules, which will provide greater clarity to hospitals. In addition, in the final rule that follows this proposed rule, CMS should reconsider whether other services could be included in the list of therapeutic services eligible for modified supervision. If CMS chooses to make no changes to this list, the agency should provide more clarity about why the therapeutic services eligible for modified supervision is limited to the 13 services listed in this rule and why more services were not included.

Hospital Outpatient Quality Data Reporting Program (HOP QDRP)

CMS has implemented a quality reporting system for hospital outpatient services known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). As required by Section 1833(t)(17) of the Social Security Act, hospitals that fail to report data for hospital outpatient quality measures specified by the Secretary for a given year will have their annual OPPS payment update factor reduced by 2.0 percentage points for the following year.

In 2008, CMS required hospitals to begin reporting data on 7 hospital outpatient quality measures in order to receive a full OPPS payment update in 2009 —five measures of emergency department (ED) care for acute myocardial infarction (AMI) and two perioperative surgical care measures. For these measures, hospitals must extract the necessary data elements from a sample of patient medical records. In 2009, CMS mandated that hospitals continue to submit data for those 7 measures to receive the full 2010 payment update. CMS also finalized a proposal to begin using

Medicare Part B claims data to calculate 4 measures of imaging efficiency[b]. These measures do not require medical record data submission by hospitals. For data reporting in 2010 (for the 2011 payment update determination), CMS continued to require the same 11 measures.

Section 1833(t)(17)(E) of the Social Security Act requires that the Secretary make the data collected under the HOP QDRP available to the public, after hospitals have an opportunity to review the data. To meet this requirement, CMS began reporting HOP QDRP data on the Medicare Hospital Compare website in July 2010, following a preview period for participating hospitals earlier in the year.

In the current proposed rule, CMS for the first time proposes the addition of new hospital outpatient measures over a three-year period, specifically for the 2012, 2013, and 2014 payment determinations. CMS notes that implementation of this proposal would not preclude the agency from proposing or changing the final lists of measures for those years through subsequent rule-making, but the intent is to assist hospitals in planning for future reporting requirements and quality improvement activities.

For the 2012 payment determination (i.e., for reporting in 2011), CMS proposes to retain the existing 11 measures and add the following 6 measures (for a total of 17 measures):

- 1 structural measure of the ability for providers to electronically receive laboratory data directly into their qualified/certified electronic health record (EHR) system as discrete searchable data (outpatient departments would report the number of encounters out of all encounters for which laboratory results were documented in the EHR).
- 4 claims-based measures of the potentially inappropriate use of certain imaging procedures:
    - Use of cardiac imaging for pre-operative evaluation for low-risk non-cardiac surgery risk assessment
    - Use of stress echocardiography, SPECT myocardial perfusion imaging (MPI), and cardiac stress MRI for asymptomatic post-CABG patients
    - Simultaneous use of brain CT and sinus CT
    - Use of brain CT in the ED for atraumatic headache.
- 1 chart-abstracted measure of whether troponin test results for ED patients with AMI or probable cardiac chest pain are received within 60 minutes of ED arrival (a measure of the timeliness of ED laboratory reporting).

For the 2013 payment determination (i.e., for reporting in 2012), CMS proposes to retain the previous year's 17 measures and add the following 7 measures (for a total of 24 measures):

- 1 structural measure to assess the extent to which a provider uses a qualified/certified EHR to track patients' pending laboratory tests, diagnostic studies, or patient referrals between visits.
- 6 chart-abstracted measures related to ED care:

[b] The following 4 claims-based imaging use measures are currently in use: MRI of lumbar spine for low back pain; mammography follow-up rates; abdomen CT – use of contrast material; and thorax CT – use of contrast material.

  - Median time from ED arrival to departure for discharged patients
  - Time from ED arrival to diagnostic evaluation by a qualified medical professional
  - Median time from ED arrival to initial administration of pain management for long bone fracture
  - Patient left ED without being seen
  - Interpretation of head CT scan results for acute ischemic stroke or hemorrhagic stroke within 45 minutes of ED arrival
  - Transition record with specified elements received by all patients discharged from ED

For the 2014 payment determination (i.e., for reporting in 2013), CMS proposes to retain the previous year's 24 measures and add the following 6 chart-abstracted measures (for a total of 30 measures):

- 5 diabetes care measures:
  - Hemoglobin A1c control in diabetic patients
  - Low-density lipoprotein (LDL-C) control in diabetic patients
  - High blood pressure control in diabetic patients
  - Dilated eye examination in diabetic patients
  - Urine screening for microalbumin or medical attention for nephropathy in diabetic patients
- 1 imaging measure: Exposure time reported for procedures using fluoroscopy

Finally, CMS invites comments on about 35 additional quality measures and measure topics under consideration for future rule-making on the HOP QDRP, including measures for healthcare associated infections, cancer care, vaccinations, heart failure care, and ED transfers.

While the Commission supports quality measurement and ultimately pay-for-performance for most Medicare providers, we are concerned about the proposed measures that rely on collecting data from medical chart abstraction. One of the key criteria we articulated in our March 2005 report is that quality measures required by Medicare should not be unduly burdensome for either the providers or CMS to collect and analyze. Process measures that can be derived from administrative claims data—such as the four proposed imaging use measures for 2012—meet this criterion. However, 13 of the 15 other measures proposed for 2012, 2013, and 2014 would require hospitals to extract the necessary data from samples of patient medical charts, which is costly and time-consuming in the predominantly paper-based medical chart environment. Data collection costs may be lower if a hospital has invested in an outpatient EHR system that can report the needed data elements, but it is not clear how many hospitals will have outpatient EHR systems by 2013 and 2014, since the current Medicare EHR incentives for hospitals are available only for the inpatient setting.

Medicare should proceed cautiously when considering whether to impose new data collection costs for chart-abstracted outpatient measures, for example by using only measures that have been evaluated and endorsed by an independent outside entity such as the National Quality Forum, and

by aligning Medicare's measures with those required by private payers so that hospitals can incur the expense of collecting the needed data once and then use it for reporting to all payers.

We also request that CMS consider whether the five chart-abstracted diabetes care measures proposed for reporting in 2013 may be better suited as physician quality measures rather than hospital outpatient department quality measures. Rather than requiring them as manually chart-abstracted measures for hospital outpatients, CMS could instead consider these useful "intermediate outcome" measures for inclusion in the physician EHR "meaningful use" criteria as those are developed over the next few years. As EHRs spread into the hospital outpatient setting, then Medicare could align these measures across the physician and hospital outpatient settings.

Last, the Commission supports the inclusion of the two structural EHR measures proposed for 2012 and 2013. The Commission strongly supports the use of EHRs and other health information technology (IT), such as computerized provider order entry and clinical decision support, as tools to improve the quality and reduce the cost of care for Medicare beneficiaries. We have specifically recommended that CMS should include measures of specific functions supported by the use of health IT, such as using an EHR to track patients with chronic conditions to send reminders about using preventive services.

ASC policy and payment recommendations

CMS proposes to maintain its policy of not requiring ASCs to submit cost data because the agency does not use ASC cost data to set or revise payment rates. CMS also expresses concern that such a requirement could be administratively burdensome for ASCs. In the Commission's March 2010 Report to the Congress, we recommended that ASCs be required to submit cost and quality data to CMS, concurrent with a 0.6 percent increase in ASC payment rates for 2011. We appreciate CMS's concern that requiring ASCs to submit cost data may be administratively burdensome, but the agency should develop a streamlined process for ASCs to submit such data, as described below. Cost data from ASCs would enable the Commission and CMS to determine the costs of an efficient provider and make more informed decisions about the ASC payment update.

ASC cost data also are needed to examine whether an existing input price index is an appropriate proxy for the costs of these facilities or an ASC-specific market basket should be developed. As described in our March 2010 Report, we are concerned that the market basket that CMS currently uses to update ASC payments (the consumer price index for all urban consumers) may not reflect ASCs' cost structure. We used data from a Government Accountability Office survey of ASC costs to compare the distribution of ASC costs with the distribution of hospital and physician practice costs. We found that ASCs have a different cost structure than that of hospitals and physician offices, and therefore the hospital market basket and Medicare Economic Index may not accurately measure changes in ASC input costs. However, the survey data used in our analysis are from 2004 and do not contain information on several types of costs. Therefore, CMS should collect new cost data and use that information to identify an appropriate price index for ASCs.

We understand CMS's concern that requiring ASCs to submit cost data may be administratively burdensome for these providers. Although ASCs are generally small facilities that may have

limited resources for collecting cost data, businesses such as ASCs typically keep records of their costs for filing taxes and other purposes. Moreover, other small providers submit cost data to CMS, including home health agencies and hospices. To minimize the burden on CMS and ASCs, CMS should create a streamlined process for ASCs to submit cost data. One such mechanism could be annual surveys of a random sample of ASCs. Another approach would be to require all ASCs to submit cost reports that are more streamlined than hospital cost reports but still have sufficient information to assess the adequacy of ASC payments and evaluate a market basket for ASC services.

Reporting of ASC quality data

Section 109(b) of the Tax Relief and Health Care Act of 2006 authorizes, but does not mandate, the Secretary to require ASCs to submit data on quality measures and to reduce the annual payment update by 2.0 percentage points in a subsequent year for ASCs that fail to do so.

In the final rule for 2008, CMS decided not to require ASCs to begin reporting quality data in CY 2008. CMS stated that the transition to a revised ASC payment system in CY 2008 posed significant administrative challenges to ASCs and that it was appropriate to allow ASCs time to gain experience with the revised payment system before introducing other new administrative burdens such as reporting on chart-abstracted quality measures. In the final rules for 2009 and 2010, CMS deferred requiring ASCs to report quality data, and proposes to do so again in the proposed rule for 2011. CMS states it intends to implement ASC quality reporting in a future rulemaking. The agency also notes that it is required by PPACA to develop a plan to implement a value-based purchasing program for ASCs; this plan is due to the Congress by January 1, 2011. CMS intends to coordinate implementation of ASC quality reporting with the value-based purchasing plan that it will develop.

In this year's proposed rule, CMS requests comments on (1) the deferral of quality data reporting for ASCs; (2) suggestions for quality measures geared toward the services provided by ASCs; and (3) potential reporting mechanisms for ASC quality data, including electronic submission of these data. In addition, they invite public comment on the following measures under future consideration for ASC quality data reporting:

- Patient fall in the ASC
- Patient burn
- Hospital transfer or admission upon discharge from the ASC
- Wrong site, wrong side, wrong patient, wrong procedure, wrong implant
- Prophylactic intravenous (IV) antibiotic timing
- Appropriate surgical site hair removal
- Surgical site infection
- Medication administration variance
- Medication reconciliation
- Venous thromboembolism measures: Outcome/assessment/prophylaxis.

As we noted in our comment letter on the proposed rule for 2009, we are concerned about further delay in implementing quality measurement for the rapidly-growing ASC setting. Our concerns are underscored by a study published in the *Journal of the American Medical Association* (JAMA) in June, which found that lapses in infection control were common among a sample of ASCs in three states[c].

At a minimum, it should be technically feasible for ASCs to report in 2011 on the following 5 quality measures that were developed by the industry-sponsored ASC Quality Collaboration and endorsed by the National Quality Forum (NQF) in April 2008:

- Patient fall in the ASC
- Patient burn
- Wrong site, wrong side, wrong patient, wrong procedure, wrong implant
- Prophylactic IV antibiotic timing
- Hospital transfer/admission upon discharge from the ASC

The first 3 of these measures are patient safety measures identified by the NQF as "serious reportable events," which are defined as errors in medical care that are clearly identifiable and measurable, usually preventable, serious in their consequences for patients, and that indicate a problem in a health care facility's safety systems. The fourth measure (prophylactic IV antibiotic timing) is similar to a measure already required to be reported for surgical patients in the hospital inpatient and outpatient settings, and it may be voluntarily reported by physicians under the Physician Quality Reporting Initiative (PQRI). Requiring the reporting of this measure by ASCs would harmonize use of this measure across four settings of care, a small but important step toward the goal of consistent use of quality measures across care settings in the future. The fifth measure, tracking ASC patients who are transferred or admitted to a hospital upon discharge from the ASC, may be a useful measure of the occurrence of adverse patient safety events during an ASC procedure. Given that all five of these measures were developed by an ASC industry coalition—and therefore their reporting presumably is considered by the industry to be technically feasible without imposing undue administrative burdens—we believe CMS should require ASCs to report on these measures without further delay.

Further, in light of the findings of the new JAMA study cited above, CMS also should evaluate how ASCs can be held accountable for surgical site infections. In particular, CMS should consider how Medicare can use the same measures to track infection rates for surgeries across hospital inpatient, hospital outpatient, and ASC settings. Because surgical site infections often do not appear until after a patient has been discharged from an ASC (or from a hospital, for that matter), CMS should consider creative methods to track these adverse outcomes. For example, CMS could perform claims data analysis to look for certain diagnoses or specific services, such as a physician office visit for treatment of an infection or dispensing of an antibiotic prescription in the 30 days following a surgical procedure. Alternatively, CMS could require hospital outpatient departments and ASCs to follow up with surgical patients one week after their procedure to evaluate their

[c] Schaefer, M.K., M. Jhung, M. Dahl, et al. 2010. Infection control assessment of ambulatory surgical centers. *Journal of the American Medical Association* 303, no. 22 (June 9): 2273–2279.

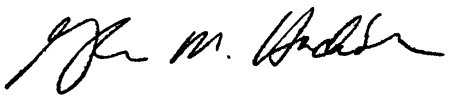
recovery and report potential infections to the physician who performed the procedure. Once clinically appropriate and administratively feasible measures have been defined for all settings where surgeries are performed, they can be used for reporting as a first step towards improving quality, with pay-for-performance as the ultimate goal. As we articulated in our June 2008 recommendation on reporting and ultimately adjusting payments based on hospitals' risk-adjusted readmission rates, Medicare should consider using measurement of surgical site infection rates as a way to encourage providers to collaborate and better coordinate care for ambulatory surgery patients.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals from CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

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