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August 31, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1589-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: File code CMS-1589-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit comments on CMS's proposed rule entitled: "Hospital outpatient prospective and ambulatory surgical center payment systems; electronic reporting pilot; inpatient rehabilitation facilities quality reporting program; quality improvement organization regulations" [CMS-1589-P]. We appreciate your staff's ongoing efforts to administer and improve the payment system for hospital outpatient departments and ambulatory surgical centers (ASCs), 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. The ASC payment system largely uses the APCs and relative weights from the OPPS, but uses a different conversion factor to obtain payment rates. 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 2013 update to the conversion factors in the OPPS and ASC payment system.

This rule also proposes to:

- Base the relative weights in the APCs on the geometric mean of estimated costs in each APC. In previous years, CMS had used the median of estimated costs in each APC as the basis for the relative weights. Because the OPPS relative weights are used in the ASC system, this affects the ASC system as well.

- Implement the composite APC Low Dose Rate (LDR) Prostate Brachytherapy (APC 8001) in the ASC system. CMS has used APC 8001 in the OPPS since 2008.
- Add no new quality measures to the Hospital Outpatient Quality Reporting Program, but suspend collection of one quality measure and defer collection of another.
- Add no new quality measures to the ASC Quality Reporting Program.
- Update the quality measures for the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP).

We focus our comments on the updates to the OPPS and ASC conversion factors and the 5 topics listed above.

Proposed 2013 update to OPPS conversion factor and adjustment to payment rates for cancer hospitals

We comment on two issues in this proposed rule regarding OPPS payment rates:

- Update the OPPS conversion factor by 2.1 percent in 2013. CMS obtained this result starting with the estimated increase in the hospital market basket of 3.0 percent and subtracting an estimate of productivity of 0.8 percent plus an additional deduction of 0.1 percentage point required by the Patient Protection and Affordable Care Act of 2010 (PPACA).
- Provide additional payments to the 11 hospitals classified as cancer hospitals under section 1886(d)(1)(B)(v) of the Social Security Act so that each cancer hospital's payment-to-cost ratio (PCR) matches the average PCR for all other OPPS hospitals.

Comments

We understand that CMS is required to implement both policies as stated in PPACA and commend CMS for their work. We note that in our March 2012 Report to the Congress we recommended an update 1.0 percent in 2013, which differs from the requirement in the PPACA.[1]

In our comment letter on the 2011 proposed rule, we expressed reservations about the proposed adjustments to the OPPS payment rates to cancer hospitals and discussed alternatives that we believe would improve this policy.[2] In addition, in the proposed and final rules for 2012, CMS has indicated the rate by which each cancer hospital's OPPS payments would be increased under this policy. In this year's proposed rule, CMS did not list the expected rates of increase. We request that CMS include this information in the upcoming final rule.

OPPS payment rates based on geometric mean costs

As part of the process for setting payment rates in the OPPS, CMS determines a relative weight for each APC, which reflects the cost of providing services in the APC relative to the base APC,

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[1] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy.*
[2] MedPAC comment letter on the proposed rule for calendar year 2011 for the outpatient PPS, August 30, 2010.

which is APC 0606 (level 3 clinic visits). By statute, CMS has the option to identify the cost for each APC as either the mean cost or median cost of all the service units in the APC. CMS has used median costs since the start of the OPPS, arguing that medians are more stable than means because they are less sensitive to data points having extremely high or low values.

In this rule, CMS proposes to use geometric mean costs in place of median costs in 2013.[3] CMS' arguments for this proposal include:

- Geometric means better reflect changes in the data that affect the distribution of costs in an APC than do medians. For example, in 2008 CMS expanded the extent to which ancillary items are packaged into the total cost of independent services. Geometric means are better able to reflect the effect that this additional packaging has on the overall cost of a distribution than are medians.
- The primary benefit offered by medians—that medians are less sensitive to extreme data points—has diminished. CMS asserts that this has occurred because hospitals now have more experience in coding under the OPPS, and CMS has made modeling improvements to obtain more accurate cost information while removing erroneous data.
- Geometric mean costs would allow CMS to detect changes in the cost of services earlier, because changes in cost often spread slowly across hospitals. While medians and geometric means both capture the impact of changes that affect all hospitals, only geometric means are assured to capture the early stages of cost changes that spread slowly across hospitals.

Comments

MedPAC believes that CMS also should have considered arithmetic means in addition to geometric means. All of the arguments that CMS makes for using geometric means also apply to arithmetic means. Moreover, we believe that arithmetic means better reflect the effect that data changes have on cost distributions. Suppose CMS makes a change in the policy for packaging of ancillary items such that it increases the total cost in an APC by 10 percent. The arithmetic mean will also increase by 10 percent, but the geometric mean will not. It may increase by more or less than 10 percent, depending on the data points that are affected and by how much.

This result is relevant to the system for setting rates in the OPPS. In this example where additional packaging causes the total cost in an APC to increase by 10 percent, using arithmetic means would result in this APC having its payment rate also increase by 10 percent (assuming no change in the cost of the base APC), whereas using geometric means would increase the APC's payment rate by an amount different than 10 percent.

In addition, CMS states in this rule that geometric means "would bring the OPPS in line with the inpatient PPS (IPPS), which utilizes … mean costs rather than median costs to form the basis of relative payment weights associated with each of the payment classification groups." However, the

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[3] For a set of *n* numbers, the geometric mean is determined as the product of the numbers taken to the nth root. In contrast, the more commonly used arithmetic mean is the sum of the numbers divided by *n*.

relative weights in the IPPS are based on arithmetic mean costs. Therefore, arithmetic means would bring the OPPS closer to the IPPS than would geometric means.

MedPAC understands that a potential drawback of arithmetic means is that data points having very high or very low values have a stronger effect on arithmetic means than geometric means. This has the potential to make payment rates based on arithmetic means less stable than payment rates based on geometric means. In addition, arithmetic means may cause greater adjustment problems for providers because they may cause larger changes from median-based payment rates than do geometric means. These reasons (or, perhaps, other reasons) may be why CMS chose to propose geometric means rather than arithmetic means.

However, CMS does not compare arithmetic to geometric means in this proposed rule, so we do not know why CMS chose geometric means. We encourage CMS to discuss whether they considered arithmetic means and why they chose geometric means over arithmetic means.

Implement low-dose rate (LDR) prostate brachytherapy (APC 8001) into the ASC payment system

In 2008, CMS attempted to increase hospital efficiency under the OPPS by creating 'composite APCs', which provide a single payment for two separately paid services when they are provided on the same day. One of these composite APCs is APC 8001: low-dose rate (LDR) prostate brachytherapy, which provides a single payment when the services represented by current procedural terminology (CPT) codes 55875 and 77778 are provided on the same day.

CMS used APC 8001 in the OPPS from 2008 through 2012, and has proposed to continue to use it in 2013. However, CMS has not used APC 8001 in the ASC payment system—paying separately for CPT codes 55875 and 77778 when provided on the same day—even though the payment rates in the ASC payment system are largely based on the OPPS. For 2013, CMS has proposed to begin using APC 8001 in the ASC system.

Comments

We support this proposal, as it is likely to result in more accurate and more stable payments for these services because paying for them separately is based on rates derived from claims that CMS has acknowledged as mostly being incorrectly coded.

Hospital Outpatient Quality Reporting Program

In this year's proposed rule, CMS does not propose to add any new measures to the Hospital Outpatient Quality Reporting Program for the purposes of determining an eligible hospital's outpatient payment update for CY 2014 and subsequent years. However, CMS has proposed to suspend collection of OP-19 (Transition record with specified elements received by discharged patients for 2014 and subsequent year payment determination). In addition, CMS has proposed to defer collection of measure OP-24 (Cardiac rehabilitation patient referral from an outpatient setting for 2014 payment determination). The earliest use of this measure would be for 2015

payment determination. Finally, we offer a comment on a structural measure that CMS adopted in last year's final rule for hospitals to begin reporting in 2013: hospital OPD volume for selected outpatient surgical procedures. The measure requires hospitals to report the volume of surgical procedures performed for eight broad categories of procedures (e.g., gastrointestinal, eye, nervous system, cardiovascular, and respiratory).

Comments

CMS cited evidence that the volume of surgical procedures—particularly high-risk procedures—is related to better patient outcomes. In addition, the National Quality Forum (NQF) has adopted structural measures of patient volume for certain surgeries performed in inpatient settings, such as esophageal resection. However, the NQF has not adopted similar measures for outpatient procedures. Because the evidence of a link between facility volume and outcomes is primarily based on high-risk procedures, we do not believe that the volume of procedures across the specified broad categories is a good proxy for outpatient department quality. Moreover, adoption of this measure could lead hospitals to increase their volume of outpatient surgeries to improve their performance on this measure, even though a link between the volume of outpatient surgery procedures and outcomes has not been demonstrated. Therefore, CMS should either eliminate this measure from the Hospital Outpatient Quality Reporting Program, or at a minimum refine the measure specifications to include only those high-risk surgical procedures where the research evidence indicates there is an association between higher volume and better outcomes.

Proposed updates to the Ambulatory Surgical Center (ASC) payment system

CMS proposes to increase ASC payments in 2013 by 1.3 percent. This proposed update is based on CMS's estimate of a 2.2 percent increase in the CPI–U minus a 0.9 percent deduction for multifactor productivity growth (PPACA requires that the update be reduced by a productivity adjustment).

CMS believes that it has statutory discretion to select the basis for updating ASC payments and has decided to base annual updates on the consumer price index for all urban consumers (CPI–U) for the last several years. However, CMS notes that the CPI-U may not be an ideal index for the cost of providing ASC services because the CPI-U is highly weighted for housing and transportation. In this proposed rule, CMS considered three alternatives to the CPI-U for updating ASC payment rates:

- the hospital market basket, which is used to update hospital payment rates;
- the physician practice expense component of the Medicare Economic Index (MEI); and
- an average of the hospital market basket and the practice expense component of the MEI.

However, CMS lacks confidence that any of these alternatives is a better proxy for ASC costs than the CPI-U because the agency does not have sufficient information on ASCs' cost structure. CMS asks for comments on the type of cost information that would be feasible to collect from ASCs to determine whether one of these alternatives or an ASC-specific market basket would be a better proxy for ASC cost changes than the CPI-U.

Comments

In the Commission's March 2012 report, we recommended an update of 0.5 percent for ASC payments in 2013. This recommendation was based on our conclusion that ASC payments have been at least adequate, the lack of ASC cost data, and our concerns about the potential effect of ASC growth on overall program spending.

Further, we agree with CMS that the CPI-U may not reflect ASCs' cost structure. As described in our March 2010 report, 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.[4] We found that ASCs have a different cost structure than do hospitals and physician offices, and therefore the hospital market basket and practice expense component of the MEI 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 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.

For the last several years, the Commission has recommended that ASCs be required to submit cost data to CMS.[5] Such data are needed to identify an appropriate market basket for ASCs. Cost data would also enable MedPAC and other analysts to determine the costs of an efficient provider, which would help inform decisions about the ASC update. We understand the concern expressed by CMS in prior rules that requiring ASCs to submit cost data may be administratively burdensome for these providers. Given the possible transition to global payments, the need for this information may diminish over time. Nevertheless, we believe reporting such data is feasible. 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 track and submit cost data. One such mechanism could be annual surveys of a random sample of ASCs (with mandatory response). An alternative approach would be to create cost reports from all ASCs that are more streamlined than hospital cost reports but still have sufficient information to assess the adequacy of ASC payments and develop an ASC market basket.

Requirements for the Ambulatory Surgical Center Quality Reporting Program

In last year's final rule, CMS established a Quality Reporting Program for ASCs that requires them to submit quality data beginning in 2012; ASCs that do not submit data would have their annual payment update reduced by 2.0 percentage points in 2014. However, Medicare payments to ASCs

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[4] Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare Payment Policy.*
[5] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy.*

would not be adjusted based on the provider's actual performance on quality measures. Although the Secretary submitted a plan to the Congress last year to implement a value-based purchasing program (VBP) for ASCs that would reward high-performing facilities, the agency lacks the statutory authority to establish such a program.

In this year's proposed rule, CMS reiterates the quality measures it adopted last year but does not propose new measures. CMS also does not discuss when and how it would publicly report ASCs' performance on these measures. CMS should develop plans to make this information publicly available to help consumers compare quality among facilities.

Comments

The Commission supports the ASC Quality Reporting Program but believes that, eventually, high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system. In our March 2012 report, we recommended that the Congress direct the Secretary to implement a VBP program for ASC services no later than 2016.[6] The current quality reporting program could lay the foundation for such a VBP program, which was the case for the Medicare hospital inpatient VBP program.

The VBP program should reward ASCs for improving care and exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services. Requiring the VBP program to begin in 2016 would give CMS sufficient time to develop quality measures, design a method for scoring measures, and determine whether ASCs attained high thresholds of quality performance or improved their own prior year performance.

Consistent with the Commission's overall position on pay-for-performance programs in Medicare, an ASC VBP program should include a relatively small set of measures to reduce the administrative burden on ASCs and CMS, and the measure set should focus on clinical outcomes, as Medicare's central concern should be improving outcomes across all ASCs and over time. The program should also include some clinical process, structural, and patient experience measures. Because the program should minimize the data collection burden on providers, CMS should avoid or minimize the use of measures that require providers to extract data from a sample of patients' medical charts. Several of these measures will be reported through the ASC Quality Reporting Program but other measures need to be developed.

CMS should consider incorporating the following outcome measures into an ASC VBP program:

- patient fall in the ASC;
- patient burn;
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant;

[6] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy.*

- hospital transfer or admission after an ASC procedure, whether the patient is transferred directly to the hospital from the ASC or admitted to the hospital after returning home from an ASC procedure; and

- surgical site infection.

Under the ASC Quality Reporting Program, ASCs will begin reporting the first three outcome measures listed above on claims in October 2012. ASCs also will begin reporting a claims-based measure tracking whether patients are transferred or admitted directly to a hospital (including a hospital emergency room) upon discharge from an ASC, which can indicate a potentially preventable complication, serious medical error, or other unplanned negative outcome. An ASC with a high rate of transfers or inpatient admissions may be providing suboptimal care or may be performing procedures on patients who should not be treated in an ambulatory surgical setting. This measure should be expanded to include patients who return home after the ASC procedure but who are admitted to a hospital shortly thereafter because of a problem related to the procedure. Including these patients in the measure would enable CMS to more comprehensively track patients who experience serious complications or medical errors related to an ASC procedure. Because some patients are admitted to the hospital after returning home from an ASC, CMS could analyze claims data to look for hospital admissions for adverse events related to an ASC procedure that occur within a certain number of days of a procedure.

Another important outcome measure is the rate of surgical site infections (SSIs) in ASCs. Researchers have found that lapses in infection control practices were common among a sample of ASCs in three states.[7] Problems with infection control could increase the rate of SSIs. Therefore, CMS should develop an SSI measure that applies to common ASC procedures. CMS should consider using the same measures to track infection rates for ambulatory surgeries for both hospital outpatient departments and ASCs. Because SSIs often do not appear until after a patient has been discharged from an ASC and because ASCs typically do not have an ongoing relationship with patients, CMS could instruct ASCs to conduct follow-up phone calls with patients, their caregivers, or their physicians within an appropriate time period after the procedure to identify patients who have developed SSIs.

Although the ASC Quality Reporting Program does not yet include an SSI measure, CMS stated in last year's final rule that it will consider proposing one in the future after the agency has identified an appropriate set of outpatient procedures for an SSI measure and developed a protocol for facilities to track and report SSIs. However, CMS did not discuss a potential SSI measure in this year's proposed rule. We request that CMS provide an update on the status of its efforts to develop an SSI measure in the final rule.

In last year's final rule, CMS indicated that a patient experience measure could be included in the ASC Quality Reporting Program in the future. However, CMS did not discuss such a measure in

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[7] 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.

this year's proposed rule. In the upcoming final rule, CMS should comment on its progress in developing a patient experience measure.

In last year's final rule, CMS adopted the following structural measure for ASCs to begin reporting in 2013: ASC facility volume for six broad categories of procedures (e.g., gastrointestinal, eye, nervous system). CMS cited evidence that the volume of surgical procedures—particularly high-risk procedures—is related to better patient outcomes. In addition, the National Quality Forum (NQF) has adopted structural measures of patient volume for certain surgeries performed in inpatient settings, such as esophageal resection. However, the NQF has not adopted similar measures for outpatient procedures. Because the evidence of a link between facility volume and outcomes is primarily based on high-risk procedures, rather than the low-risk procedures commonly performed in ASCs, we do not believe that the volume of ASC procedures is a good proxy for ASC quality. Moreover, adoption of this measure could lead ASCs to increase their volume to improve their performance on this measure, even though a link between the volume of outpatient surgery procedures and outcomes has not been demonstrated. Therefore, CMS should eliminate this measure from the ASC Quality Reporting Program.

Requirements for the Inpatient Rehabilitation Facility Quality Reporting Program

As required by PPACA, CMS established a quality reporting program for inpatient rehabilitation facilities (IRFs) in last year's rule-making cycle. In the FY 2012 IRF PPS final rule, CMS established two measures for the IRF quality reporting program for FY 2014: urinary catheter-associated urinary tract infections and pressure ulcers that are new or have worsened. The rule also discussed ongoing development of a 30-day all-cause risk-standardized hospital readmission measure that CMS stated it intends to propose once development is complete. In this year's rule, CMS proposes refinements to the two finalized measures and to the measure adoption process.

Comments

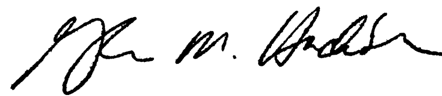
The Commission emphasizes its support for CMS developing and including a risk-adjusted hospital readmission measure in the IRF quality reporting program. In the upcoming final rule, CMS should comment on its progress in developing this measure. We also encourage CMS to consider adding a measure of functional improvement since regaining functional status represents a central goal of IRF care. A recent RAND study that we commissioned measured industry performance on five risk-adjusted measures from 2004 to 2009, including all-cause hospital readmission within 30 days after discharge to the community and functional improvement on the IRF Patient Assessment Instrument. The study found that while raw rates of hospital readmission worsened over time, risk-adjusted rates improved. While results suggest that risk-adjusted quality of IRF care has improved overall since 2004, this work highlights the need for ongoing quality measurement in these important areas. The RAND study is available on our website, and we are available to discuss the findings with CMS staff in more detail.

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 E. Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/dz/wc