August 31, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1633-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare Dependent, Small Rural Hospitals Under the Hospital Inpatient Prospective Payment System; Proposed Rule

Dear Mr. Slavitt:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the calendar year (CY) 2016 proposed rule: Medicare Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare Dependent, Small Rural Hospitals Under the Hospital Inpatient Prospective Payment System published in the Federal Register on July 8, 2015.

The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Our comments below are presented in the order in which they appear in the proposed rule.

I. Updates to the Ambulatory Surgical Center Payment System

As we have previously commented, we consider the Consumer Price Index for Urban Consumers (CPI-U) unsuitable to update payments for ambulatory surgical centers (ASCs) because it does not accurately represent the changing costs borne by facilities to furnish surgical procedures. Instead, the CPI-U is...
an index that measures the average change over time in the price of consumer goods. The vast majority of units tracked to render the CPI-U do not reflect expenditures related to healthcare, let alone the purchasing experience of an ASC.

The ASC payment system is also one of the last Centers for Medicare & Medicaid Services (CMS) payment systems to be tied to the CPI-U. Other payment systems use indices derived from the basket of goods actually purchased by those providers.

We urge the agency to align ASC payment updates with the OPPS payment updates by using the inpatient hospital market basket for both settings. While we appreciate that the hospital market basket does not perfectly align with the ASC cost structures, the hospital market basket is more representative of the cost structure than the CPI-U or other existing factors. Therefore, we request that CMS begin updating the ASC payment system with the hospital market basket starting with CY 2016.

II. REQUIREMENTS FOR THE HOSPITAL OUTPATIENT QUALITY REPORTING PROGRAM

Outpatient hospitals are subject to a reduction of 2.0 percentage points to their outpatient department (OPD) fee schedule update factor for failure to meet requirements for the Hospital outpatient quality reporting (OQR) Program.

New Measures Beginning with the 2018 and 2019 Payment Determination

OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases

CMS proposes to add the following web-based quality measure to the Hospital OQR Program starting with the 2018 payment year: OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822). This measure, which is intended to ensure that palliative radiation therapy is delivered with an appropriate number of fractions, is National Quality Forum (NQF)-endorsed and was recommended for use in the program by the Measures Application Partnership (MAP). The PPS-Exempt Cancer Hospitals Quality Reporting (PCHQR) Program also previously adopted this measure starting with the 2017 payment year. The ACS believes this is a well-constructed measure that targets the very important issue of unnecessary radiation exposure, while...
at the same time aiming to provide patients with shorter and less painful treatment options.

Administrative and Data Submission Requirements

Data Submission Time Frames

CMS also proposes to change the data submission timeframe for measures submitted via the CMS Web-based tool (QualityNet Website) from July 1 through November 1 to January 1 through May 15 of the year prior to the payment determination with respect to the encounter period of January 1 to December 31 of two years prior to the payment determination year. This proposal aims to streamline hospital data submissions by ensuring consistency with proposed data submission deadlines for the Ambulatory Surgery Center Quality Reporting (AQSCR) Program in this rule.

While the ACS appreciates CMS’ effort to streamline data submission requirements and minimize provider reporting burden, we would like to remind the agency of our ongoing concerns with the two-year gap between the reporting and payment adjustment periods. This extended timeframe makes measures less meaningful and actionable to the provider that is being held accountable and limits the effectiveness of using measures as a tool for quality improvement. **We understand that the two-year gap is an inherent limitation of claims-based measures and therefore encourage CMS to rely more heavily on measures that are instead based on clinical, cloud-based registry data.**

We are specifically concerned about the following two chart-abstracted measures and urge CMS to convert these measures to clinical data-driven measures that rely on real-time analytics:

- OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (chart abstracted); and
- OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (chart abstracted)

ACS is happy to work with CMS to develop cloud-based, clinically-driven solutions that improve the actionability and overall utility of these and other measures.
III. REQUIREMENTS FOR THE AMBULATORY SURGICAL CENTER QUALITY REPORTING PROGRAM

Administrative and Data Submission Requirements

ASC-12: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

In this rule, CMS notes that ASC-12: Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (NQF #2539) was not NQF-endorsed at the time it was adopted for the ASCQR Program, which was a concern raised by the public last year, but that now it is NQF-endorsed.

Last year, when this measure was first proposed for inclusion in this program, ACS supported it in concept, but voiced several concerns regarding exclusions to the measure as currently specified. In order to prevent the unfair distortion of measure results, the measure developer notes that they have excluded only those high-risk procedures and patient groups for which risk adjustment would not be adequate or for which hospital visits were not typically a quality signal. Certain conditions such as inflammatory bowel disease are considered high risk and therefore excluded from the denominator of this measure. However, there are additional clinical indications that also may be associated with a higher risk for admission unrelated to the physician and treatment, which are not excluded from the denominator. Through last year’s rulemaking process, ACS requested that the following high-risk indicators be excluded from the measure specifications: patients with acute diarrhea, partial obstruction, massive lower GI bleed, and volvulus. Other commenters questioned why this measure uses an all-cause categorization versus only admissions attributable to colonoscopies.

In the 2015 final rule, CMS acknowledged ACS’ request for excluding high-risk indicators from the measure, but did not directly address the issue or finalize any changes. CMS simply clarified that this measure is purposely designed to use a broad outcome of hospital visits following surgery rather than a narrow set of easily identifiable complications. CMS noted that the goal is to encourage and inform provider efforts to minimize all potential acute complications, not just those narrowly related to procedural technique. CMS also noted that the literature suggests that hospital visits following colonoscopy occur due to a range of adverse events relating to the bowel preparation,
anesthesia, the colonoscopy procedure itself, and follow-up care. These adverse events include a range of symptoms and signs such as abdominal pain, bloating, dizziness and collapse, electrolyte disturbances, and cardiorespiratory symptoms (from sedation use) in addition to other complications, such as bleeding and bowel perforation, that are directly related to procedural techniques. According to CMS, the broad outcome of unplanned hospital visits captures all of these potential acute complications of colonoscopy. We appreciate CMS’ response, but we reiterate our previously stated concerns that the exclusions as currently specified should be expanded to include procedures and patient groups with a high risk of admission unrelated to the physician or treatment.

IV. SHORT INPATIENT HOSPITAL STAYS

Proposed Policy Change for the Medical Review of Inpatient Hospital Admissions under Part A

Under the current 2-midnight rule, a hospital inpatient admission will be considered reasonable and necessary if a physician orders the admission based on the expectation that (1) the beneficiary’s length of stay will exceed 2 midnights, or (2) the beneficiary requires an inpatient-only procedure. Such inpatient admissions are presumed generally appropriate for Part A payment and are not the focus of medical review efforts. Instead, review efforts focus on inpatient stays of less than 2 midnights, which CMS believes are generally not appropriate.

CMS proposes to change its medical review policy for short hospital stays to provide for Part A payments for inpatient hospital stays of less than 2 midnights in duration if, based on the clinical judgment of the admitting physician, the patient requires a reasonable and necessary inpatient admission and the medical record shows support for that determination. CMS also announces that Quality Improvement Organization (QIO) contractors will conduct reviews of short inpatients stays instead of Medicare Administrative Contractors (MACs) or Recovery Audit Contractors (RACs).

We support both of these changes. We appreciate the change to the 2-midnight rule that would base the appropriateness of an inpatient admission not on the length of time services will be required, but instead on a physician’s determination of the need for inpatient services after evaluating the factors that
relate to the patient’s clinical condition. We also thank CMS for instructing QIOs to take over the first-line medical reviews of short inpatient stays, and we agree that this will foster a more collaborative approach to education and enforcement.

We appreciate the opportunity to provide comments regarding this proposed rule. The ACS looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Vinita Ollapally, Regulatory Affairs Manager, in our Division of Advocacy and Health Policy. She can be reached at vollapally@facs.org or at (202) 672-1510.

Sincerely,

David B. Hoyt, MD, FACS

Executive Director