American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

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Kate Goodrich, M.D.
Acting Director
Quality Measurement and Health Assessment Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

RE: Public Comment – Development, Maintenance, and Support of ACA 3005 PPS-Exempt Cancer Hospitals Quality of Care Measures

Dear Dr. Goodrich:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on these three potential measures for the prospective payment system (PPS)-exempt cancer hospital quality reporting (PCHQR) program:

- Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer or Lung Cancer;
- Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis; and
- Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy.

Mathematica Policy Research (MPR) and the National Committee for Quality Assurance (NCQA) are developing the measures under a contract with the Centers for Medicare & Medicaid Services (CMS). These measures also are being field tested at several PPS-exempt dedicated cancer hospitals. We commend CMS and the measure developers for seeking broad input on the measures during their developmental stage and well in advance of the measures being formally proposed for the PCHQR program.

All three measures assess important aspects of cancer care, and the AHA supports their continued development. However, we strongly urge the measure developers and CMS to fully utilize field testing in dedicated cancer hospitals to ensure each measure is sufficiently rigorous for a public reporting program and can be feasibly collected without undue burden. We also strongly urge CMS to obtain endorsement of the measures from the

National Quality Forum (NQF), as well as pre-rulemaking review by the Measure Applications Partnership (MAP) before formally proposing any of the measures for the PCHQR program. Below are our overarching comments applicable to all of the measures followed by specific comments concerning each measure under development.

GENERAL COMMENTS

The AHA strongly supports the commitment of CMS and PPS-exempt cancer hospitals to use publicly reported quality measures to help drive continuous improvement to cancer care. While it is laudable that CMS is embarking on this new effort to develop an effective quality reporting program so that consumers, purchasers and providers have important information about the quality of care provided at cancer hospitals, it will take time to identify the most salient issues, develop enough measures, and craft a useful "report card" on the critical aspects of care at these hospitals. In assessing whether the three proposed measures should be part of that report card, it would be most useful to know what CMS expects the entire report card will look like, and how these measures fit into the creation of that full picture of quality in cancer hospitals. Otherwise, commenters are forced to simply review the properties of the measures themselves and comment on the fitness of the measures, without being able to assess the appropriateness of these measures in the context of the reporting program. **The AHA urges CMS to articulate its broad vision for the measures in the PCHQR program.**

The broad vision for the measures in the PCHQR program also should reflect the unique care delivery model of dedicated cancer hospitals. Assessing care in such hospitals is particularly challenging because reliable measurement requires a sufficiently large number of patients for the data to be stable statistically. However, cancer hospital patients receive treatment plans tailored to the needs of their specific type of cancer, and that plan may encompass a broad continuum of services, including surgery, inpatient hospital stays, and outpatient chemotherapy and radiation treatments. Because of the broad range of cancer types treated in cancer hospitals, we believe CMS would be hard-pressed to develop sustainable process and outcome measures that assess every kind of cancer treated at cancer hospitals.

Instead, CMS's vision for the PCHQR program should focus on measures of broad, cross-cutting issues that affect many cancer patients. This focus would provide the most useful information to a large number of patients who might be considering where to get their treatment and to hospitals seeking to improve the care they provide. Unfortunately, there are few cancer hospital-specific measures that address issues such as care coordination, functional status, patient safety, patient experience and efficiency, which are exactly the kind of cross-cutting issues we anticipate the report card should address. **Although the measures we have been asked to comment on do not address all of these areas, the measures do have a broad scope and assess care for a variety of patients treated at dedicated cancer hospitals. For that reason, they are appealing as potential measures to use in the PCHQR program.**

As with all measures intended for public reporting, the proposed measures also must generate reliable measure results and be feasible to collect without undue data collection burden to cancer hospitals. Measure field testing allows hospitals to gain experience with collecting and reporting

the measure and illuminates important areas where the measure can be improved. **We applaud the measure developers' efforts to engage dedicated cancer hospitals in field testing and believe the testing process has already yielded tangible areas for improvement that should be addressed before the measures are used in the PCHQR program.** AHA members that are part of the field testing efforts have noted the following concerns, which are applicable to all three measures.

Data collection burden. The measure developers propose to use electronic health records (EHRs) as the data source for all three measures, although data collection via manual chart abstraction also is being tested. Data collection using EHRs holds the promise of less burdensome data collection than retrospective manual chart abstraction. EHR data collection also has the potential to provide more precise data than administrative claims data.

To date, the experience of field test sites suggests that both data collection methods have significant opportunities for improvement. EHR extraction has yet to yield measure results consistent with those of manual chart abstraction. Hospitals note that the methods of electronic data extraction vary across hospitals. If these inconsistencies are left unresolved, electronic abstraction is unlikely to generate the comparable data across different hospitals needed for a public reporting program. Unfortunately, the alternative data collection strategy – manual chart abstraction – appears to be an unsustainable solution if measure collection is to be scaled up across multiple hospitals. One site reported that extracting data on the osteoclast inhibitor measure for a single patient takes approximately nine hours.

Given that EHR abstraction has shown inconsistent results and that the current manual chart abstraction approach is highly labor intensive, the AHA recommends that the measure developers create a sampling methodology for manual chart abstraction. This approach would allow cancer hospitals to abstract needed data in the short term, but make it less burdensome. The developers should continue to explore EHR-based reporting as a long-term solution. However, a fully developed manual abstraction methodology that incorporates sampling may allow for the measure to be used in the PCHQR program sooner.

Coding issues. We urge the measure developers to work closely with the field testing sites to ensure that any administrative coding data used to identify applicable patient populations and care interventions are accurate. When abstracting data for a measure, diagnosis codes are used to more efficiently identify the patient population applicable to the measure. However, field test sites have noted that the current codes sometimes exclude patients and interventions that would otherwise be appropriately included in a measure, leading to inaccurate measure results. For example, one of the proposed measures assesses the proportion of breast cancer patients who receive imaging studies even though they are at low risk for the cancer spreading. The codes currently used to identify imaging studies appear to be incomplete, which may lead to an undercounting of the patients who receive unnecessary imaging studies. The field testing phase of measure development is an ideal time to ensure that codes include the correct diagnosis and care interventions.

INITIATION OF OSTEOCLAST INHIBITORS FOR PATIENTS WITH MULTIPLE MYELOMA OR BONE METASTASES

Osteoclast inhibitors are drugs intended to stem bone deterioration in patients with multiple myeloma (a cancer affecting the bone marrow), or bone metastases. The measure assesses the percentage of patients who are administered an osteoclast inhibitor drug in the 60 days following diagnosis of either multiple myeloma or a bone metastasis associated with breast, prostate or lung cancer. In the fiscal year 2014 inpatient PPS rule, CMS proposed to add a similar measure to the PCHQR program that narrowly focuses on the use of one kind of osteoclast inhibitor (bisphosphonates) for multiple myeloma patients. The AHA opposed the inclusion of that measure because of its limited scope and evidence suggesting that bisphosphonates may not be appropriate for all multiple myeloma patients. Thus, we appreciate that the measure under development by MPR and NCQA has a much broader focus.

However, as noted previously, we urge the developers and CMS to ensure that the codes used to collect measure data include the appropriate patient population and care interventions. The developers and CMS also should work closely with field test sites to ensure that codes are correctly interpreted, and do not lead to erroneous conclusions about cancer hospital performance. The code interpretation issue becomes especially complex when concurrently using two or more diagnosis codes. For example, suppose a patient has diagnosis codes for both bone metastasis and prostate cancer. While prostate cancer can cause bone metastases, it does not always do so. As currently written, the measure may inadvertently include patients whose bone metastasis is not associated with prostate, lung or breast cancer, thereby enlarging the measure's patient population (i.e—the measure denominator). This may result in an inaccurate lowering of a cancer hospital's score on the measure because the measure denominator would include more patients than intended.

OVERUSE OF IMAGING FOR BREAST CANCER PATIENTS AT LOW RISK OF METASTASIS

The proposed measure assesses the percentage of women over 18 years at low risk of metastasis who have certain imaging studies (CT, PET or PET/CT scans) performed in the 120 days after an initial breast cancer diagnosis. Patients with stage 0, 1 or 2 breast cancers are considered "low risk" in the measure. The basic assumption of the measure is that imaging studies have limited value for breast cancer patients whose disease is unlikely to spread. The AHA agrees that avoiding unnecessary care is an important issue. Given the prevalence of breast cancer, we also believe this measure has an appropriately broad focus.

However, measure field testing suggests that the measure developers must addresses several issues to improve measure accuracy. As with the other measures, the measure developers should carefully review the codes with the testing sites to ensure they include all appropriate patients and imaging studies. Testing sites also have noted that cancer stages can change over time, so the measure must be clear about what timeframe is considered to be the date of "initial diagnosis." Finally, the measure developers should consider excluding patients on research treatment protocols that may require more frequent imaging studies. Indeed, cancer

hospitals are at the forefront of clinical research and often treat patients that are on research protocols.

POTENTIALLY AVOIDABLE ADMISSIONS AND EMERGENCY DEPARTMENT VISITS

The proposed measure assesses the percentage of cancer patients receiving outpatient chemotherapy who have had either an admission to an inpatient hospital or a visit to the emergency department (ED) for a number of cancer-related complications (e.g., pain, nausea, neutropenic fever, dehydration, etc.). To date, the measure developers have been focused on using claims data to capture this measure, although the limited measure specifications posted for comment suggest that EHRs also may be used to collect data.

The AHA is concerned about the potential for unintended consequences in measuring hospital admissions and ED visits of outpatient chemotherapy patients. The measure developers and CMS must consider the impact such a measure may have on treatment decisions. Cancer patients choose therapies that range from aggressive to palliative. Dedicated cancer hospitals work with patients to provide treatments that are best tailored to individual patient needs and preferences. If not carefully implemented, publicly reporting ED department visits for chemotherapy may indirectly discourage more aggressive treatment plans. **Given the sensitivity of this issue, the measure developers should thoughtfully engage with cancer hospitals, as well as patients and families, to determine what type of patient population should be included in the measure.** Opinions on an appropriate measurement focus are likely to vary, and must be carefully weighed. For example, the measure could include only patients on palliative treatment regimens.

In addition, the AHA is concerned about the scientific validity of using only administrative claims data to capture the measure. In assessing admissions and ED visits among chemotherapy patients, the measure developers assume that such episodes are caused by how chemotherapy is administered. However, our cancer hospital members note that it is not always clear whether the complications (e.g., nausea, pain) included in the measure are the result of chemotherapy rather than tumor progression. Using claims data alone may not provide sufficient detail to make this important distinction. **Therefore, we encourage the measure developers to explore how to couple claims data with the more detailed information available in a patient medical record to improve the measure.**

Thank you again for the opportunity to comment. If you have questions, please contact me or Akin Demehin, senior associate director for policy, at (202) 626-2365 or ademehin@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

cc: Measure Developers (NCQA and MPR), via NCQA's online comment submission portal (http://publiccomments.ncqa.org)