March 28, 2014

The Honorable Marilyn Tavenner, R.N.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Administrator Tavenner:

The undersigned organizations strongly support public reporting and quality measurement, however we have serious concerns with a measure scheduled to become effective on April 1, 2014 for both the ambulatory surgery center (ASC) and hospital outpatient department (HOPD)/. The measure is OP-31/ASC-11 (NQF 1536) *Cataracts – Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery.* The measure was not created for and is not appropriate for measuring quality at the facility level in these settings. In short, the measure is not appropriate as a facility measure, and, therefore, we respectfully request the measure be withdrawn or permanently suspended.

Although the agency has undertaken an effort to modify the measure specifications, compliance with the measure will place unnecessary and administratively burdensome responsibilities on the facilities and physicians without attendant improvements in the care provided to patients. In mandating that ASCs and HOPDs be subject to quality reporting, Congress intended that facility-level measures relate to the episode of care within the facility, encompass data that is available within the facility, be collectable by the facility staff, and produce conclusions that are actionable by the facility. This measure would appear to meet none of these benchmarks.

The measure was originally specified for use by clinicians. The measure was adopted for use in the HOPD and ASC setting prior to it being specified for those settings. In addition, the re-specified measure was never tested in the facilities for which it was re-specified. It was not sent back to NQF for re-consideration with the new specifications. Therefore, NQF was unable to evaluate the feasibility as part of a re-endorsement process for a new setting.

The measure, as specified for the clinician setting, is collected by a third party (to avoid bias) and reported via registry under the Physician Quality Reporting System (PQRS) as one measure in a four-measure set. Moreover, physicians who elect to report on this measure provide data for a minimum of 20 patients, while facilities would be required to report on the same measure for 64-96 patients, a substantially more burdensome task.

We appreciate that CMS has listened to concerns about the specifications released on December 31, 2013 and has since re-specified the ACS-11 to align with OP-31 on the data element of administering a pre- and post-op visual function test. Now both the hospital and the ASC can administer a visual function test pre- and post-cataract procedure, and not have to involve the physician or their office. However, we still maintain this methodology does not facilitate communication between the physician and hospital or ASC as CMS has said was the intent of the measure. In addition, CMS has

not provided complete measure specifications that will permit the vendor to incorporate the specifications in such a way to ensure consistent interpretation across all vendors and hospitals/ASCs.

We are concerned that the agency's adoption of NQF 1536 is the result of its apparent confusion regarding the difference between *visual acuity* – which is a Medicare program requirement and an objective scientific measurement routinely administered and recorded by the surgeon on a pre-and post-op basis on the patient's chart – with *visual function*, the measurement of which is limited to those surgeons choosing to report on the registry-based cataract measures group. Regardless, it is inappropriate to migrate a measure from the physician's office to other settings without testing it on a pilot basis, a concern that has been expressed by MedPAC and the Measure Applications Partnership with respect to NQF 1536.

Combining our concerns about measure specifications with the lack of specificity about survey administration and no true pilot testing makes this measure a paper chase that utilizes precious hospital and ASC resources without any impact on improving patients' care or outcomes.

We are all in agreement that the Medicare quality reporting program should help us assess the quality of care provided by facilities and generate meaningful information to beneficiaries that will enable them to make informed choices as to an appropriate surgical site of service. We strongly recommend that OP-31/ASC-11 be withdrawn or suspended indefinitely. We also recommend that the agency consider working with our organizations to identify more appropriate alternative measures that more effectively and efficiently evaluate, and provide opportunities for improving the quality of patient care provided by the ASC and HOPD communities.

If you have any questions, please feel free to contact Jayne Hart Chambers (Federation of American Hospitals, 202-624-1522), Cherie McNett (American Academy of Ophthalmology, 202-737-6662), or Michael Romansky (Outpatient Ophthalmic Surgery Society, 301-332-6474). We look forward to further discussions with CMS on this topic.

Sincerely,

American Hospital Association
America's Essential Hospitals
Ambulatory Surgery Center Association
American Society of Cataract and Refractive Surgery
American Academy of Ophthalmology
Association of American Medical Colleges
Federation of American Hospitals
Outpatient Ophthalmic Surgery Society