



**American Hospital
Association**

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Submitted electronically
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RE: CMS-2420-NC, Medicaid Program; Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults; Notice (Vol. 75, No. 250), December 30, 2010

Dear Dr. Clancy:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Agency for Healthcare Research and Quality's (AHRQ) notice of the Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults.

The Patient Protection and Affordable Care Act (ACA) required the Secretary of Health and Human Services (HHS) to identify and publish a recommended core set of adult health quality measures for Medicaid-eligible adults. The states could use these measures voluntarily to collect information on the quality of the health and health care of Medicaid-eligible adults. On December 30, 2010, AHRQ published a proposed initial core set of adult health quality measures. The agency developed the list of measures by convening a committee of state Medicaid representatives, health care quality experts and representatives of health professional organizations and associations that reviewed measures from nationally recognized sources, such as the National Quality Forum (NQF), and convened a public meeting to take comments on suggested measures. Fifty-one quality measures are included in the recommended initial core measure set.

The proposed measure set marks a positive step toward measuring quality for the Medicaid adult population; however, we are concerned that the proposed list lacks the focus and prioritization that could truly drive patient care forward. We suggest that there are several national frameworks that AHRQ may look to when identifying priorities, namely the National Quality Strategy and the work of the NQF's National Priorities Partners. In addition, we urge AHRQ to examine the successes of previous public reporting programs, such as the Medicare hospital quality reporting initiatives, and use lessons learned from prior experience to build a concise, focused initial core measure set. Our detailed comments are included below.



We believe that determining a national framework for quality reporting was an important part of what Congress wanted to achieve when it adopted provisions in the ACA to create a National Quality Strategy. HHS is expected to issue a final version of the strategy soon, but a preliminary set of national priorities already exists in the work of the NQF's National Priority Partners, in which AHRQ and other federal agencies participate. The goal of the Partners' national priorities is to engage all stakeholders in a shared effort to make quality improvements in the most important areas of patient care. The use of a common set of national priorities will help focus public reporting programs on high-leverage, important areas and align the various national reporting programs among different health care providers and settings. Alignment will become even more critical as public reporting continues to expand beyond the hospital and physician Medicare reporting programs to other health care settings and the Medicaid program.

Characteristics of meaningful measures. Once AHRQ identifies a conceptual framework for the Medicaid adult quality measures, it is critical that meaningful measures be selected for implementation. Measures chosen for public reporting should be important measures that accurately and reliably assess meaningful aspects of care. We suggest that AHRQ look to criteria recently developed by The Joint Commission, which has spent considerable time examining what makes some measures better than others. It concluded that excellent measures:

- Have a large volume of research linking the measure to improved outcomes;
- Accurately assess whether evidence-based care has been delivered;
- Address a process that is close in proximity to the desired outcome; and
- Ensure implementation with minimal unintended adverse consequences.

In the past, improvements in quality have been achieved by: focusing on a few, high priority areas; understanding the steps that are critical to achieving the best outcomes; choosing measures that assess whether those steps are being performed reliably; testing and sharing strategies for enabling clinicians to reliably perform those necessary steps; and using the data to inform and motivate further action. AHRQ's proposed list of 51 measures provides states and providers with little direction as to where they should focus. We suggest that AHRQ look to the initiation of the Medicare hospital quality reporting program as a model for implementing a new measurement program.

Roll out measures in a manageable number. The hospital quality reporting program began with a starter set of 10 measures reflecting three clinical topics: heart attack, heart failure and pneumonia. A small number of new measures were added each year. As new measures have been introduced, hospitals have focused on each new measure and increased quality improvement efforts in those areas. The results have been remarkable, as noted in AHRQ's "National Healthcare Quality Report." Hospitals' overall performance has improved, sometimes rapidly, on every single measure added to the Medicare hospital quality reporting program. The national median score is now 90 percent or higher for most of the measures that are reported, and those hospitals with the lowest baseline scores at the introduction of a measure have improved the most. This system has worked beyond expectations. The AHA suggests that AHRQ use a similar concise set of measures in the beginning of a Medicaid-eligible adult reporting program.

The initial core measure set should consist of only a handful of measures in key leverage areas. Then, as states and providers gain experience with the measures, it may be appropriate to add new measures to the core set.

NQF endorsement. The AHA believes that it is critical that measures selected for the initial core measure set be vetted through the quality measurement community. This is primarily achieved through the consensus development process advanced by the NQF, which evaluates the scientific soundness of measures. Through the NQF, interested health care stakeholders come together to choose measures that are useful for quality improvement and public reporting. The NQF vets quality measures against criteria that assess the measures' importance, scientific acceptability, feasibility and usability. Eleven of the 51 measures proposed for inclusion in the initial core measure set are not currently NQF-endorsed. **The AHA strongly believes that only NQF-endorsed measures should be included in national reporting programs, and we urge AHRQ to withhold those measures that are not NQF-endorsed from the core measure set.**

Clinical conditions. In the proposed initial core measure set, the measures are categorized by whether they assess prevention and health promotion issues, acute care, chronic condition management, patient experience or availability of care. While these are appropriate broad categories, we suggest that AHRQ also examine the list of measures based on the clinical conditions they cover. The AHA has long advocated that measures be adopted for use in public reporting programs primarily in measure sets centered on particular clinical topics. The use of measure sets allows providers to gain more insight into their quality performance than one or two measures alone can provide. In addition, collecting data on clinically related sets of measures can lessen the reporting burden to providers because each individual measure adds only a few unique data elements to the collection process.

When we examine the proposed measures, there are several that appear to cover the same clinical topic, but they may not be considered a measure set because the patient populations included under the measures are not identical. For example, there is a measure assessing the rate of hospitalization for hypertension at a community level and another measure that examines the proportion of patients with hypertension who had their blood pressure under control. There are several measures on managing the medications of bipolar and schizophrenic patients and another measure on mental health utilization. It would be helpful if AHRQ could assess how well the proposed measures fit into measure sets around particular clinical populations. Only measures that fit within a discrete set should be finalized in the adult core measures set.

Accountability for measures. Finally, we note that the proposed measures include a mix of population and provider-based measures. It is not clear who is to be held accountable for each type of measure. Are some for health plans and some for providers? Will states report on the broad population measures for their state-wide Medicaid populations? We ask that AHRQ provide some clarity in the final notice on whether each measure is intended to be a provider, plan or state-level measure.

Hospitals are committed to providing the highest level of quality care to all patients and are pleased to see this recognition of a vulnerable population for which few public reporting efforts

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have been initiated. If you have any questions about our comments, please contact me or Beth Feldpush, senior associate director for policy, at (202) 626-2963 or bfeldpush@aha.org.

Sincerely,

Rick Pollack

Executive Vice President