



**American Hospital
Association**

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Submitted electronically

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, S.W., Room 445-G
Washington, DC 20201

***RE: CMS-9962-NC, Request for Information Regarding Health Care Quality for Exchanges,
November 27, 2012***

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding health care quality measurement and reporting for health insurance exchanges. *The Patient Protection and Affordable Care Act* (ACA) requires health plans participating in the exchanges to collect and publicly report quality data. It also requires CMS to develop a system to rate the quality of health plans on the exchanges to assist consumers with comparing and selecting plans.

America's hospitals will be called upon to help implement these new quality measurement and reporting requirements. While CMS will select the specific quality measures used on the exchanges, hospitals and other providers will need to report data to health plans on these metrics. This will require hospitals to allocate significant resources for the collection and reporting of quality measures. Given the active role hospitals will play, CMS also will need to develop administrative processes that address how relevant quality data are collected from hospitals. Finally, CMS will need an approach for publicly displaying performance data in a meaningful, understandable way for consumers to use in assessing quality.

As CMS plans the implementation of quality measurement and reporting requirements for health plans in the insurance exchanges, we offer four overarching recommendations:



- **Quality measures selected for use in the health insurance exchanges should be aligned with those already used in existing federal programs.** The challenge of meeting multiple, and often non-aligned quality measurement and reporting requirements poses a significant burden to hospitals.
- **CMS should implement strategies to encourage alignment and reduce the burden of measurement and reporting for insurance exchanges.** Many of AHA's recommended strategies would allow CMS to leverage processes the agency already uses in other quality measurement and reporting programs.
- **CMS should ensure there are clear, transparent administrative processes for hospitals to submit data to health plans, compare performance against benchmarks, and verify the accuracy of data used in public reporting.** These processes will ensure that health plans have accurate information about hospital performance, and that hospitals can use measures in part to assist in internal quality improvement efforts.
- **Finally, in developing a rating system for health plans, CMS should balance measures that assess hospital and provider quality with measures that assess health plan quality, including the ability to link patients to services.**

The comments below are organized around these four core recommendations, and respond to several of the 15 questions listed in the RFI. We have noted the RFI questions relevant to each set of recommendations for reference.

THE BURDEN OF NON-ALIGNED QUALITY MEASUREMENT AND REPORTING ACTIVITIES (RFI QUESTION 2)

While the AHA recognizes the value of many quality measurement and reporting requirements, we are concerned about the significant burden these requirements place on hospitals and other providers.

In the past decade, there has been an unprecedented expansion in the number and type of quality measures on which hospitals are required to report. Federally mandated pay-for-reporting, value-based purchasing and other performance programs have been a key driver behind this growth. Indeed, the Measure Applications Partnership (MAP), a public-private, multi-stakeholder partnership convened by the National Quality Forum (NQF) to review measures under consideration for use in federal programs, is reviewing more than 500 measures in more than 20 federal payment and reporting programs.¹ Hospitals are affected by at least 100 measures in 10 of the programs being reviewed by the MAP. In addition to any federal requirements, hospitals also must collect and report on quality measures to fulfill requirements from accreditors (e.g., The Joint Commission), states, private insurers and others.

Hospitals incur significant financial expense to collect and report on quality measures. No method of measuring and reporting hospital performance is "free," and some methods are particularly costly. For example, chart-abstracted measures require a hospital staff member to

¹The list of measures under consideration can be found at <http://www.qualityforum.org/map/>.

manually review a patient's medical record against criteria defined in a measure to determine performance. Accurate abstraction of chart-based measures is often impossible without clinically credentialed personnel, leading hospitals to incur higher costs when reporting on additional chart-abstract measures becomes required. Moreover, many chart-abstracted measures are highly detailed and complex, requiring significant time to review. For example, the surgical care improvement measures that are part of the hospital inpatient quality reporting program have a specifications manual of more than 170 pages. And, once the data are abstracted, hospitals also incur expenses to vendors, which transform the data into a form usable for reporting and analysis by CMS. Many chart-abstracted measures have significant value in measuring performance. However, they must be implemented with care given the resources needed to use them.

Other measures have lower front-end data collection costs, but still require significant time and expense to review and report. Quality measures reported via claims (e.g., mortality and readmissions rates) rely on coding to report performance. However, hospitals must review performance reports for accuracy, as well as educate coding and other administrative staff to ensure accurate recording of the information used to derive the measures. Similarly, measures collected through survey tools, such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience instrument, require that hospitals pay a vendor to collect and report on performance.

Hospitals recognize the need to invest in quality measurement and reporting, but their spending decisions are made much more difficult by the lack of alignment in measurement applications and performance expectations across programs. Individual programs often use different measures to assess the same care process or outcome. For example, in Massachusetts, hospitals report on patient falls in at least three ways. They must report falls resulting in death or disability via the state-mandated Serious Reportable Event program. They also may voluntarily report on both fall and fall injury rates via PatientCare Link², which provides the ability to benchmark with others across the state. Both of these state-based measures contrast to the claims-based measure of falls used in the Medicare hospital-acquired condition payment penalty program. Collection and reporting on each of these measures requires resources, and because their methodologies are different, there are limited opportunities for efficiencies. Moreover, each measure yields a different type of score, making it more difficult to ascertain true performance.

The financial cost of collecting and reporting measures, combined with the inconsistencies in measures and performance outlined above, can impede hospitals' ability to identify and implement organizational quality improvement priorities. Hospitals have finite quality measurement and improvement resources. Thus, the time and money spent collecting and reporting quality measures could mean fewer resources dedicated to improving performance.

STRATEGIES FOR ENHANCING ALIGNMENT AND REDUCING MEASUREMENT BURDEN (RFI QUESTIONS 2, 6 AND 9)

With improving care as an overarching goal for all of these initiatives, we recommend that CMS implement strategies that have the greatest potential for aligning quality measurement activities,

² <http://www.patientcarelink.org/>

such as those described below. Many of these recommendations draw upon CMS's existing mechanisms for selecting measures for quality reporting programs. By achieving alignment, there is an opportunity to reduce the burden of quality measure data collection and free up resources for quality improvement

First, measures selected for any federal program – including the insurance exchanges – should be driven by a common set of national priorities for quality improvement and public reporting. The National Quality Strategy has provided a framework for these priorities, and the National Priorities Partnership (NPP) provides a forum for identifying specific goals that address the needs of multiple stakeholders. The NPP is convened by NQF, and includes participants from a broad array of federal agencies, including CMS. Such efforts to identify concrete goals can promote the parsimonious selection of quality measures, reducing the burden of collection. Thus, we encourage CMS to actively engage with the NPP in the development of quality measurement rules for insurance exchanges.

Second, CMS should use only quality measures endorsed by NQF. NQF-endorsed quality measures are reviewed by multi-stakeholder committees using rigorous evaluation criteria.³ Endorsed measures produce reliable and valid results, are usable for accountability programs, and are feasible to collect and report. NQF also has developed the MAP to provide input to the Department of Health and Human Services (HHS) on which measures to use in federal payment and reporting program in advance of formal rule-making. **We strongly urge CMS to use the MAP to review any specific quality measures it plans to include in health insurance exchanges, and to encourage the MAP to strive for parsimony and focus in selecting measures.**

Finally, we urge CMS to consider measurement approaches that balance accountability on national priorities with the ability for hospitals to measure and improve quality issues of specific concern to their organizations. This principle, recently advocated by the quality leaders of several large health care organizations,⁴ should be considered for all federal quality reporting programs, including health insurance exchanges. Hospitals are firmly rooted in their local communities, and have quality improvement opportunities unique to their patient populations and workforces. For example, some hospitals may have strong processes and favorable outcomes for healthcare-acquired infections, but also have opportunities to improve medication safety practices. However, hospitals often default to addressing the quality measurement and improvement needs of federal programs because of the significant resources required to comply with them.⁵

Instead, we encourage CMS to ensure health plans only require hospitals to report on a limited, parsimonious set of measures. These measures would include process, outcomes, patient experience and efficiency. Hospitals would then need to select other quality measures tailored to address their specific improvement needs. Such an approach may allow hospitals to direct their

³ NQF measure endorsement criteria can be found at <http://www.qualityforum.org>.

⁴ Meyer GS et al. More quality measures versus measuring what matters: A call for balance and parsimony. *BMJ Qual Saf* 2012; 21: 964-968

⁵ Meyer GS et al. More quality measures versus measuring what matters: A call for balance and parsimony. *BMJ Qual Saf* 2012; 21: 964-968

limited measurement and improvement resources toward both national priority areas and other issues that are specifically problematic for their organizations.

RECOMMENDED ADMINISTRATIVE PROCESSES FOR PUBLIC REPORTING OF QUALITY MEASURES (RFI QUESTIONS 9, 11 AND 12)

While the recommendations in the two previous sections focused on how specific quality measures should be selected for health insurance exchanges, the processes used for actually reporting the data on the measures are also critically important. We offer two key recommendations to ensure a clear and transparent reporting process:

First, when reporting on hospital and provider measures, CMS should ensure that all data reporting methods and performance benchmarks used by plans on the exchanges are fully available to providers. Hospitals strive to be data-driven when identifying improvement opportunities and implementing enhanced care processes. To effectively use metrics to track progress, hospitals must know what information is being collected, as well as the performance targets. Hospitals also must have access to detailed data that allows them to understand exactly where their performance falls short. For example, if the health plan uses a composite of several measures, hospitals should have information on their scores on each component of the composite, along with a benchmark for each component. Without this level of transparency, there is a significant risk that resources will be misdirected.

Similarly, performance data collected by health plans should be made available to providers before they are publicly reported. Providers should have an opportunity to review data and make corrections if needed. Quality measurement and reporting are inherently complex activities. A review process would help ensure that performance is measured accurately, and that consumers use the correct information to evaluate health plans and providers.

CONSIDERATIONS FOR RATING HEALTH PLAN PERFORMANCE (RFI QUESTIONS 11 AND 12)

Finally, we wish to offer two general recommendations about the health plan rating system that CMS will need to develop:

- **When rating a health plan, HHS should consider measures that assess the role health plans play in linking patients to services.** Health plans aggregate the scores of hospitals and other providers on clinical quality metrics to help assess the overall quality of the plan. While we agree with performance being reported this way, we also urge health plans and CMS to include measures that assess the performance of health plans in linking patients to services. Several of the measures used to rate Medicare Advantage plans may be considered for health plans in the insurance exchanges, such as ease of getting appointments with specialists and wait times for appointments.
- **The AHA also urges caution in attempting to characterize health plan performance using only a single score, such as a letter grade.** Quality and safety requires measurement using a variety of data sources and perspectives. It is exceedingly difficult

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to create any one measure that fully reflects any hospital's performance. We believe this is also the case for health plans.

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

Sincerely,

/s/

Ashley Thompson
Vice President and Deputy Director, Policy Development