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Association**

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January 24, 2013

George Isham, M.D, and Elizabeth McGlynn, PhD
Co-Chairs, Measure Applications Partnership
c/o National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005

RE: Measure Applications Partnership Pre-Rulemaking Draft Report

Dear Drs. Isham and McGlynn:

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 comment on the Measure Applications Partnership's (MAP) 2013 pre-rulemaking report. The AHA strongly supports the premise of the MAP's work—that is, improvement in our nation's healthcare system can be catalyzed by selecting quality measures in federal reporting and payment programs focused on aspects of care that a broad array of stakeholders believe to be important.

We also believe that the MAP's goal of fostering stronger alignment between quality reporting and payment across care settings and programs is critically important to the long-term success and sustainability of health care quality improvement efforts. Broadly defined, alignment means that measurement priority areas are the same across payment programs. It also means that the decision to use particular measures in a particular program is driven by a consistent set of principles. At a time when health care resources are under intense scrutiny, the alignment of quality reporting and payment efforts across settings and programs would reduce the data collection burden and the unnecessary duplication of efforts. Alignment also would help balance the allocation of limited resources between data collection and actual efforts to improve performance. The AHA appreciates the progress of the MAP in improving the alignment of quality reporting efforts across programs this year.

Moving forward, we urge the MAP to take additional steps to more concretely enhance the alignment of quality measurement reporting and payment efforts. The MAP has several operational and strategic levers at its disposal to promote stronger alignment. For example, the MAP can incorporate concrete guidance for measure selection into its process. Moreover, the MAP's statutory mandate to review all quality measures being considered for federal programs



affords it a unique strategic opportunity to look across programs and measures, identifying tightly scoped, actionable areas in which strong measures are available to drive improvement across settings and programs. This year's committee deliberations, as well as the draft report, contain many crucial building blocks to take this next step. Thus, as the MAP finalizes its report, we offer the following recommendations:

- The Hospital and Clinician Workgroups developed guiding principles to help inform the selection of measures across programs. Similarly, the Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup identified several measurement areas – such as patient engagement, care coordination and safety – that lend themselves to quality improvement across multiple care settings. **We recommend that the MAP integrate the principles and priority areas into one overarching set of guidance that can be applied to all programs that it reviews.** We recommend a potential integrated set of principles in the next section.
- **The AHA also recognizes that some individual programs may require principles that reflect their specific needs and goals.** Given our role in the Hospital Workgroup, we have offered suggested edits to the hospital principles to align them with our recommended overall principles.
- The MAP stands at the intersection of measure endorsement, driven by the National Quality Forum (NQF), and measure implementation, governed by the Centers for Medicare & Medicaid Services (CMS). Given its unique positioning, the MAP can strategically use its own processes to drive alignment efforts, as well as recommend process changes to NQF and CMS that enhance the MAP's effectiveness. Specifically:
 - **To further promote alignment and a focus of quality measurement resources across the health care delivery system, the MAP should identify two or three specific priority areas for measurement each year, and recommend that CMS implement them across its programs.** This approach would go one step beyond an examination of the relative numbers of MAP-recommended measures in each priority area of the National Quality Strategy (NQS). Instead, the MAP would select a limited number of aspects within a priority area, such as patient safety, to address aggressively each year with available measures.
 - **To allow for adequate time to vet individual measures, and strategically select priorities across programs, the MAP should recommend that CMS provide a list of measures under consideration earlier in the process.**
 - **To better understand the burden of measurement, the MAP should urge NQF to undertake a study so that such considerations can be incorporated in MAP's deliberations.**

AN INTEGRATED SET OF MAP MEASURE SELECTION GUIDING PRINCIPLES

We commend the work of the Hospital and Clinician Workgroups in developing guiding principles for measure selection.¹ These principles demonstrate the clear progress that the MAP has made in harnessing the input of multiple stakeholders to inform its decisions. We also appreciate the PAC/LTC Workgroup's identification of "high-leverage" areas of performance measurement most likely to stimulate improvement across multiple care settings.² When taken together, the guiding principles and high-leverage measurement areas are highly relevant to all of the programs that the MAP reviews. Moreover, these combined principles and high-leverage measurement areas provide concrete, step-wise guidance that can be applied easily during MAP committee deliberations to foster greater alignment of quality measures across federal programs. We have consolidated the principles from the workgroups, as well as the priority measurement areas from the PAC/LTC Workgroup, into a single set of principles for use by all MAP workgroups:

1. **Measures under consideration for CMS programs should be chosen to ensure a focus on the areas patients, providers and other stakeholders believe to be most important.** The MAP believes patient engagement, care coordination, safety and cost/access are critical aspects of care for which there should be care setting-appropriate measures across programs.
2. **Measures used in reporting and payment programs should be consistent with the purpose and goals of each program.** Inclusion of each measure should support improvement in the safety, quality and efficiency of care delivered to the patients whose care is actually covered by that program.
3. When measures used for public reporting and in pay-for-performance programs successfully encourage changes in the way care is delivered, there can be unintended, negative consequences. **CMS should work with other key stakeholders to monitor for these unintended consequences and, when appropriate, take steps to decrease the chances of negative effects from the unintended consequences;** for example, including measures that provide a countervailing pressure.
4. **The MAP believes that there is a logical sequence of actions for implementing measures in federal programs:**
 - a. *All measures should be reviewed and endorsed by the NQF prior to inclusion in a federal program.* This is meant to ensure that each measure is important, scientifically sound, useable and feasible to collect.
 - b. *Each measure should then be included in a national public reporting program for at least one year prior to inclusion in a pay-for-performance program.* In this manner, the results can be monitored to be sure that there is variation in

¹ These are identified in Appendices H and I (pp. 198-201) of the MAP pre-rulemaking draft report. The report can be accessed at: <http://www.qualityforum.org/map>.

² These areas are outlined in Table 1 (p. 37) of the MAP pre-rulemaking draft report. The report can be accessed at <http://www.qualityforum.org/map>.

performance; the causes for variation are identified and, if related to patient characteristics (such as severity of illness), appropriate adjustments are made to the measure; and potential unintended consequences of measurement and public reporting can be identified and addressed.

- c. *Measures identified as being sufficiently important and having performance that is not uniformly excellent should be considered for inclusion in an appropriate pay-for-performance program where the incentive/disincentive will provide greater inducement for change.*
 - d. *Monitoring of a measure's performance should continue throughout its use in a pay-for-performance program. When there is evidence of consistent and sustained excellent performance, the measure should be retired from performance-based incentive programs and public reporting programs. This will create room for identification of additional improvement opportunities and inclusion of new measures.*
 - e. *In rare instances, some of the steps in the sequence may be skipped, such as when a measure has already been reported broadly in another national quality data collection program or when the issue is considered to be so urgent that adoption of the measure into public reporting or inclusion in an incentive program is needed immediately. Exceptions to the sequence outlined in steps 4a-4d should be rare. The process should be the one typically used because each step is critical to ensuring patient care is changed in ways that are likely to improve outcomes, and that providers are fairly compared.*
5. **The NQF endorsement status of measures currently used in, or being proposed for, quality reporting and payment programs should be applied in a number of ways:**
- a. Measures that are not NQF-endorsed, but are already finalized in programs should be submitted for NQF review. If a measure does not receive endorsement, it should be removed from the program.
 - b. Measures that lose their NQF endorsement also should be removed from the programs.
 - c. **NQF-endorsed measures used in federal programs must be applied in a manner consistent with how the measures are specified and tested when endorsed. If CMS intends to use a given measure differently in a program, the measure should not be implemented until testing results for this new use demonstrates a comparable level of reliability and validity as when it was initially reviewed by the NQF.** Since NQF endorsement is predicated on measures being used as developed, the same data collection methods and patient populations must be used in federal programs.
6. **It is important that there be parsimony in the selection of measures** to ensure the providers being measured are focused on critical aspects of care that need improvement,

and to ensure patients can find information without being overwhelmed by data. **Parsimony can sometimes be enhanced by using the same measure in multiple programs. However, careful consideration should be given to how the programs work together, whether inclusion in two programs creates the right emphasis on an issue, and whether there is the opportunity for confusion coming out of the disparate applications of a measure.** Specifically:

- a. If the same measure is used in more than one pay-for-**reporting** program, the performance benchmarks, data collection periods and performance periods must be consistent across programs.
- b. **The same measure should not be used in more than one pay-for-performance (i.e., payment penalty) program** because there are often inconsistencies in the programs' goals, reporting methods and performance benchmarks. These inconsistencies can lead to confusion about the true state of organizational performance. Instead, if CMS wishes to strongly emphasize a measure, that measure should be given a greater weight within one penalty program.

APPLICATION OF OVERARCHING MEASURE SELECTION PRINCIPLES TO HOSPITAL PROGRAMS

We fully support the MAP's proposal that articulated principles are needed to help all stakeholders understand what makes a measure appropriate for one program, but perhaps not appropriate – or not *yet* ready or appropriate – for another. The principles in the previous section apply to all programs, but each program often has its own unique issues with applying measures. Thus, the AHA recommends several edits to the Hospital Workgroup's guiding principles to align them with the overall guiding principles outlined above, and to address specific areas of concern.

Inpatient and Outpatient Quality Reporting. **The AHA largely agrees with the principles articulated for the Inpatient Quality Reporting (IQR) program**, especially the first principle, which states that measures ought to first be publicly reported for at least a year before being considered for inclusion in a pay-for-reporting program. Hospitals have more than a decade of history in public reporting of quality metrics. As clearly documented in *The Joint Commission's 2012 Annual Report: Improving America's Hospitals*, hospitals have responded to publicly reported data with substantial improvements in care on most measures. Inclusion of high priority measures in the Inpatient and Outpatient Quality Reporting Programs encourages progress while also giving hospitals the opportunity to learn of potential unintended consequences, biases in the data, or barriers to improvement that must be dealt with to enable better care. It also allows policymakers time to identify the measures that warrant the added emphasis of linking payment to performance to generate improvement.

We also strongly support the notion of parsimony articulated in the last principle. Changing existing processes to get better outcomes requires energy, resources and focus, and that means being judicious about how many measures are chosen for application to each sector of the health care delivery system.

The AHA’s only suggested change in this section of the Guiding Principles is to simply add “and Outpatient Quality Reporting” to the heading. While we realize the Hospital Workgroup was only evaluating the IQR measures at the time these principles were articulated, we see no reason to believe these principles would be any different for the outpatient counterpart program, and therefore urge the MAP to make this adjustment.

Value-Based Purchasing (VBP). The AHA also supports the concepts articulated in the principles on VBP, including the principle suggesting that measures (or composites) included in VBP should demonstrate opportunities for improved performance. We do, however, suggest some language changes.

One of the sub-bullets addresses measures with concerns about potential unintended consequences. The notion of unintended consequences is ubiquitous in measurement, but the likelihood of such an occurrence varies with the subject matter being assessed and the amount of pressure brought to bear on performance by inclusion in pay-for-reporting and/or pay-for-performance programs.

For example, there is growing concern about the unintended consequence of creating more antibiotic resistant organisms as we measure whether or not surgical site infection prevention steps and the pneumonia treatment steps occurred in a timely fashion in the IQR system, even before such measures were linked to payment. We believe that monitoring for unintended consequences should be ubiquitous, and that policymakers should consider implementing steps to prevent unintended consequences. This is especially important when considerable pressure is being brought to bear for performance, or the potential severity of the unintended consequence is significant.

Thus, we suggest that the second sub-bullet under VBP be included in the more general statement of principles for which we advocate above. If the MAP chooses not to adopt that suggestion, then the following bullet should be moved to the “Additional Considerations” section of the hospital principles to make clear it is not simply a principle for VBP measures:

- *AHA-suggested language: Unintended consequences can occur when measures used for public reporting and pay for performance successfully encourage changes in the way care is delivered. HHS should work with other key stakeholders to monitor for these unintended consequences and, when appropriate, take steps to decrease the chance of ill-effects from the unintended consequences, such as by including measures that provide a countervailing pressure.*

Hospital-Acquired Conditions (HAC) Payment Penalty Program. In articulating principles for the Hospital Readmissions Reduction and HAC Payment Penalty Programs, the MAP suggests it would be important to consider overlapping incentives and their unintended consequences. We believe that the MAP meant to address overlapping incentives between these two programs and the VBP program. We suggest the following language to clarify:

- *AHA-suggested language: In adopting a measure for pay-for-performance programs, stakeholders should consider whether the measure is appropriate for more than one*

program, such as the VBP and HAC programs. The different constructs of the programs and the disparate ways in which good versus bad performance is identified could potentially send conflicting signals to the providers being measured because their performance in one program could appear acceptable or even good, but in the other program may appear unacceptable or deserving a payment penalty. To avoid such conflicting signals, it may be appropriate to consider giving heavier weight to a measure in one program, and removing it from the other.

With regard to the use of claims-based measures for the identification of HACs, we continue to believe that claims represent an inadequate data set from which to cull the clinically relevant information that is needed to identify HACs. We are particularly concerned about using claims to identify relatively rare events, such as many of the conditions in the current HAC payment program that do not allow a patient to be moved into a higher-paying diagnosis-related group (DRG) as a result of a HAC. When the HAC occurs rarely, even one misidentification from the claims data can adversely impact the hospital's payment. This is particularly concerning if Medicare uses claims-based measures that were validated on all payer databases, but applied for payment purposes to Medicare fee-for-service (FFS) data only. A report CMS commissioned from Mathematica showed how unreliable many of these measures are when applied only to the Medicare FFS claims.³

We urge the MAP to express an explicit preference for measures that have been demonstrated to be reliable and valid in the way CMS intends to use them. In many instances, CMS uses the measures as they were reviewed by NQF, and NQF endorsement should be sufficient justification of the measure's scientific acceptability, if used as reviewed. However, where CMS will use a measure in a manner other than intended by the NQF, the AHA urges the MAP to directly state that the measure must be separately tested and verified that it is reliable and valid.

Readmissions. The AHA supports the principles articulated with regard to the readmission measures that should be included in the Hospital Readmissions Reduction Program. In particular, we support the second sub-bullet under the bullet that begins, "Particularly salient points from the MAP Guidance ...". This sub-bullet urges that readmission measures should exclude planned readmissions. The algorithm created by Yale University researchers to give some consistency to the exclusion of planned readmissions is a significant improvement over the initial readmission measure specifications.

However, there is a growing body of research supporting the notion that improving care across the continuum in ways that will lead to better outcomes and fewer readmissions is a "team sport." It will require appropriate action not only by the hospital, but by providers in the community, the patient and the family. When the community lacks a sufficient number or array of other providers, or other environmental factors interfere with a patient's path toward wellness, it is unfair to hold the hospital responsible for those factors.

³ This report can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HVBP_Measure_Reliability-.pdf

We urge the MAP to call explicitly for consideration of socioeconomic adjustments in measures that rely on actions outside the control of the hospital as a principle guiding the selection of readmission measures and other measures that span the care continuum.

STRATEGIC ADVICE FOR THE MAP TO MAXIMIZE ITS IMPACT

The integrated measure selection guiding principles are but one tool that MAP can use to encourage alignment across programs. As the MAP enters its third year, it is poised to play an even more pivotal role. The MAP's statutory mandate to review all quality measures being considered for federal programs affords it a unique opportunity to look across programs and measures, identifying the health care delivery system's best opportunities for aligned measurement. The MAP also can work with its key partners – CMS and NQF – to recommend and implement process changes that enhance its effectiveness in executing its role. The AHA's strategic recommendations to the MAP are outlined below.

Identification of Concrete Measurement Priorities. The MAP has a unique opportunity to identify tightly scoped, actionable areas in which strong measures are available to drive improvement across care settings and programs. **The MAP could identify the top two or three priority areas for measurement each year and suggest that CMS implement them aggressively across its measurement programs.** High-level quality measurement and improvement priorities have been outlined in the NQS. The MAP's draft report illustrates that MAP-recommended measures address each priority area within the NQS. However, we recommend that the MAP select a limited number of aspects within a priority area, such as patient safety, to aggressively address each year with available measures. This prioritization will allow for resources to be focused, increasing the likelihood of success. At the same time, this prioritization strategy facilitates parsimony.

The draft report details a large number of measure gaps. While identifying such gaps is important and should continue, it can take years to develop the measures that fill identified gaps. In the meantime, the MAP could encourage a more concentrated effort to improve quality in certain priority areas where enough measures to succeed already exist.

MAP Specificity of Recommendations on Measures. **The MAP also should include additional categories or rationales for committee decisions on measures** beyond the established criteria of Support, Support Direction, Phased Removal, Do Not Support or Insufficient information. In particular, this year's MAP discussions revealed that the term "Support Direction" was ambiguous. For example, in some circumstances, members may agree to support the direction of a measure conditioned upon NQF endorsement. In other situations, members may agree to support the direction of a measure that is not fully specified because they would like to see a more robust development of that measure. Committee decisions should be communicated to CMS with more clarity.

MAP Recommendations to CMS. CMS is a critical partner in the MAP review process. CMS not only provides the list of measures for review, it also actively participates in committee discussions. The AHA encourages the MAP to provide concrete guidance to CMS each year about how it can enhance the quality of its participation in the process. In this year's report, we

suggest that the MAP include a section titled “Recommendations to CMS on the MAP Review Process” that conveys the following:

MAP participants have repeatedly requested, in both MAP and external meetings, that CMS provide a list of the measures under consideration earlier than Dec. 1. In the last two review cycles, MAP members have been asked to review hundreds of measures within a two-week period to prepare for the workgroup meetings. Given that MAP members are volunteers with full-time jobs, this timeframe makes meaningful review of the measures very challenging. In fact, at times, the Hospital Workgroup discussions demonstrated that members are struggling to gain a command over the substance of the measures they have been asked to review. Further, the short timeframe makes it difficult for MAP participants to solicit and receive comments from their organizational members, who often possess important insights about how well a measure will achieve its objectives and what can be done to improve it. In terms of widely vetting quality measures, this outreach is important.

MAP members have suggested using a “rolling” release of measures under consideration, which could take place throughout the year. Others have suggested an earlier transmittal of the full list of measures under consideration to the MAP – at least 60 days earlier than the current timeframe. **We strongly urge CMS to adopt either or some combination of both strategies so that MAP members can provide well-researched, thoughtful and meaningful feedback to CMS. At the same time, CMS should use the guiding principles articulated by the workgroups to limit the number of measures under consideration provided for MAP review.**

Finally, the MAP plays a vital role in assessing the acceptability, value and feasibility of quality measures for inclusion in the payment and penalty programs. Given the MAP’s crucial role in bringing together stakeholders to comprehensively evaluate whether a measure makes sense for a particular program, we encourage CMS to propose only measures for rulemaking that have been considered by the MAP.

MAP Recommendations to NQF. The NQF serves as the health care sector’s primary organization for coordinating quality measure development, endorsement and review across a wide spectrum of conditions and care settings. Given NQF’s integral role in the MAP review process, we encourage the MAP to provide NQF the following guidance.

First, we encourage the NQF to study and provide information on the burden of quality measurement so that the MAP can use it in its deliberations. Measures should be recommended for payment and penalty programs only when they add value, and should never be implemented simply because a process or outcome *can* be measured. There must exist a way for providers to improve care based on the results of the quality measure data. Otherwise, resources for quality improvement are wasted.

The AHA has begun to collect information from its members on the burdens of quality measurement, and we look forward to sharing our knowledge with the NQF and MAP. Our initial findings demonstrate that the types of burdens of quality measurement vary for the different types of data collected. For example, abstracted measures are particularly cumbersome

to collect because of the time and labor involved and the detailed nature of the work, while HCAHPS measures cause hospitals to incur substantial costs for vendor support.

As NQF studies the issue of measurement burden, the AHA recommends NQF consider the following issues:

- The types of labor involved in each type of data collection, including abstracted, survey reported, structural and claims-based data collection.
- The time involved for providers to learn about and implement the measures as they change.
- The time involved for providers to collect and report the data.
- The costs for technology and vendor assistance.
- The barriers that exist to successful implementation of quality measures.

We also recommend that NQF provide additional information to the MAP on whether measures recommended for individual programs are actually tested for those settings. Providing this information in advance of MAP committee deliberations on measures would help expedite the review process. In no circumstance should a measure approved for one setting be endorsed for a second setting before the measure is tested in the second setting.

CONCLUSION

With a consolidated set of guiding principles for measure selection and enhancements in its strategic positioning, the AHA believes the MAP would be poised to play an even more crucial role in driving measurable improvement within the health care delivery system. Thank you 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/

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