American Hospital Association

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February 12, 2014

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

RE: CMS Quality Strategy, submitted electronically

Dear Ms. Tavenner:

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 respond to the Centers for Medicare & Medicaid Services' (CMS) request for comments on its proposed Quality Strategy, specifically, the role CMS intends to play in advancing its objectives.

We commend CMS on articulating its Quality Strategy, which provides greater detail on how the agency will contribute toward the broader goals of the Department of Health and Human Services (HHS), and we appreciate that CMS has requested comments from all interested stakeholders in an effort to strengthen and invite alignment with its plan. CMS clearly recognizes that there are still great opportunities for better information to drive care improvements.

The AHA has worked enthusiastically along-side CMS since the early days of national quality efforts, and we are eager to continue our productive work with the agency. Part of that work has included the Hospital Quality Alliance, in which we worked collaboratively with several other interested stakeholders to identify measures, collect data and publicly report on hospital quality. Since then, CMS has taken a strong national leadership role in advancing quality measurement and its use. CMS also has partnered with numerous other provider groups, such as the American Medical Association and physician specialty societies, cancer hospitals, psychiatric hospitals and other providers, to develop quality metrics and public reporting tools that have promoted quality improvement and provided better information for the public.

To that end, we offer the following thoughts about potential improvements in CMS's Quality Strategy:

1. Quality measures used for public reporting and payment systems. Health care delivery reform has been focused on achieving the Triple Aim – better health, better care, lower cost – and on the opportunity for consumers to engage more fully in their own health care. The enormous effort underway to achieve this transformation demands a national alignment of quality measures capable of stimulating, supporting and tracking progress. One of the most important actions CMS can, and should, take is to **create greater alignment and focus across the agency's quality measurement activities.** The challenge of meeting multiple, and often non-aligned, quality measurement and reporting requirements poses a significant burden to hospitals and other providers in collecting data. Unaligned, disparate requirements confuse the public and other users of the data as they attempt to assess how well the health care system as a whole, or their community providers, are doing. And, most importantly, non-alignment becomes an impediment for improvement efforts in trying to determine which practices and processes are most likely to lead to the best outcomes for patients.

   We believe that HHS, as a whole, would foster improvement most effectively by establishing clear and meaningful national goals with specific and measurable objectives that could be used throughout the department. CMS then could use these goals and objectives to align and streamline its quality measurement and reporting efforts, measures embedded in payment programs and other regulatory activities, such as conditions of participation and conditions of coverage, to stimulate the accomplishment of the objectives.

   Broadly defined, alignment means that measurement priority areas are the same across payment programs, and that the decision to use particular measures in a particular program is driven by a consistent set of principles. It could mean, if appropriate, using the same measure in different programs. For example, a well-crafted measure of pressure ulcers can be used in every setting where patients are at risk.

   However, the AHA is concerned that CMS's approach to alignment thus far has been too focused on ensuring the same measures or similarly named measures are used in more than one program. This has resulted in providers feeling the measures on which they are assessed do not fit particularly well with the work they do. We urge CMS to first focus instead on unifying efforts toward the accomplishment of a common set of goals. In so doing**,** it might choose different measures for various types of providers, but it could articulate a clear concept of how the work of all providers could come together to achieve the identified quality objective. For example, if the goal is to reduce early mortality from heart disease, one might construct a series of aligned measures in which primary care clinicians are assessed on their ability to manage blood pressure and diabetes in their patient population, hospitals and their care teams are assessed on door to balloon times or other relevant aspects of their proficiency in re-profusing the heart muscle quickly, and

cardiac rehab facilities are assessed on their ability to improve patients' ability to return to activities of normal living.

At a time when safety and quality improvement strategies offer enormous potential for improving patient outcomes and when providers are under intense pressure to manage health resources wisely, an aligned, focused approach to quality measurement, pay-for-performance and regulatory programs, based on a unified and common set of goals and objectives, will ensure that efforts are focused on achieving improvement in a critical set of priority areas. Alignment will drive the most meaningful improvements across the health care delivery system. **We believe that CMS will more effectively engage the health care field in improvement if it chooses measures for specific programs that address the role that providers in that program have in helping to achieve a consistent set of measurement and improvement priorities across the health care system.**

We urge CMS to begin this work in collaboration with the National Priority Partnership – a body that was originally envisioned as a multi-stakeholder group that could provide important input to HHS on a small number of specific national priority areas. CMS can then work with the Measure Applications Partnership (MAP) to identify the measures that best address these priorities within each payment or public reporting program. It can ask the MAP to pay particular attention to the role that the providers in any given program have in helping to achieve the overarching objectives, and ensure that measures can be chosen to identify how well the providers are doing as they contribute toward common goals.

2. Remove barriers to greater alignment. In addition to aligning quality measures in its reporting and incentive programs, CMS should consider further how to align other critical parts of its quality and safety portfolio with its policy objectives. For example, CMS is experimenting with various forms of payment that are intended to create greater incentives for safe, patient-centered, efficient care, such as accountable care organizations, bundled payments and medical homes. These new and promising forms of payment were created under experimental authority, but some of the lessons learned from these programs can inform CMS's work to improve communication and coordination along the entire care continuum for patients, and to prompt standardization of practice when appropriate for achieving better patient outcomes. The requirements and provisions that were waived for the organizations experimenting with these new forms of payment provide a starting point for identifying policies that should be changed.

   CMS's conditions for coverage (CfCs) and conditions of participation (CoPs) exist independently for the different types of providers paid by CMS under distinct programs, but these CfCs/CoPs can hamstring provider efforts to integrate across the care continuum and to reduce variation in care. If CMS wants providers, including hospitals and post-acute care organizations, to take a more holistic approach to the care of patients, the agency should consider whether its approach to oversight of those

organizations and its requirements within each of those programs supports or impedes achievement of care integration.

The AHA recently commented on one such proposed change to the CoPs. CMS proposed to prohibit hospitals within a health system that have separate CMS Certification Numbers (CCNs) from creating a unified medical staff. A unified medical staff can facilitate the establishment and use of common practice guidelines, better communication about individual patients, and shared information technology systems. CMS' proposed rule seems caught in the old concept of siloed and independent health care provider organizations whose structures are designed to reinforce that independent work. However, this old concept seems inconsistent with CMS's new priorities for care to be more coordinated along the path of the patients, with providers communicating and working more collaboratively for the patient's benefit.

3. Remember that providers must balance national priorities with community specific needs. 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 already have driven their infection rates low, but have significant opportunities to improve medication safety or reduce diagnostic errors. While no national measures have yet been adopted for these areas, it would be a shame to thwart efforts to improve these aspects of care by putting such demand on the hospital for measures and initiatives that there is no further capacity to work on local priorities. In developing its Quality Strategy, we urge the department and CMS to be mindful of the burden being imposed on providers, and to leave sufficient opportunity for providers to innovate, engage with their communities and public health officials, and pursue critical public health and organization specific improvement opportunities.

Thank you again for the opportunity to comment. If you have questions, please contact me or Nancy Foster, vice president for quality and patient safety policy, at (202) 626-2337 or nfoster@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development