



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

January 21, 2014

Marilyn Tavenner
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-3288-NC, Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology, November 19, 2013

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 comment on the Centers for Medicare & Medicaid Services' (CMS) proposed framework and list of quality measures for the Quality Rating System (QRS) for Qualified Health Plans (QHPs) on health insurance exchanges. *The Patient Protection and Affordable Care Act (ACA)* requires health plans participating in exchanges to collect and publicly report quality data, and for CMS to develop a system to rate the quality of health plans on the exchanges to assist consumers with comparing and selecting plans.

The AHA supports several aspects of CMS's proposed framework and measures list for the QRS. However, we are concerned that the measures list seems more like a list of available and potentially implementable measures, rather than a list chosen to advance underlying strategic priorities. We fully understand that CMS has to start the QRS with those measures that are available, but the agency also should lay the strategic groundwork for moving the nation from where we are currently to where we want to be with measuring quality and access for health plans. This groundwork should consider how measuring health plan quality aligns with the quality measurement in other parts of the health care system in order to create meaningful information that both informs all stakeholders and encourages important improvements with a minimum amount of burden.



Thus, the AHA recommends that CMS take additional steps to ensure that QRS measures are focused on the most important national quality improvement priorities, QRS data accurately reflect health plan performance, and that the QRS provides patients with the most meaningful information in selecting health plans. Specifically, we recommend the following:

- **CMS, in collaboration with other agencies and interested parties, should conduct research to identify the driving factors that help consumers select the plan that is right for them.** These driving factors should drive CMS’s choice of measures and future efforts to develop relevant measures. **Similarly, the agency should identify the relatively small set of high priority quality improvement goals it has for a year,** determine what role health plans have in advancing progress toward achieving those goals, and select those health plan quality measures most relevant to achieving those goals.
- **Each year, CMS should submit the list of measures it is considering for the QRS to the multi-stakeholder Measure Applications Partnership (MAP) to enhance alignment with national quality improvement priority areas.**
- **CMS should use only those measures that are endorsed by the National Quality Forum (NQF) for measuring health plan performance to ensure measures are sufficiently rigorous for public reporting.**
- **CMS should consider including additional measures that provide more meaningful, explicit information about patient access and affordability.**

GETTING TO THE BEST MEASURES FOR THE QRS

The AHA strongly believes that all federal quality measurement and reporting programs – including the QRS – should be aligned around a common set of national priorities for quality improvement. Broadly defined, alignment means that measurement priority areas are consistent across programs, and 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, an aligned, focused approach to quality reporting can lessen data collection burden and unnecessary duplication of efforts. America’s hospitals are directly affected by whether the QRS is aligned with existing quality reporting and pay-for-performance programs. Indeed, while the QRS is intended to assess the performance of QHPs, hospitals, physicians and other providers may need to allocate resources to collect and report measures to QHPs in order for QHPs to meet their reporting requirements.

The AHA is pleased that several aspects of the proposed QRS framework’s guiding principles and measure selection criteria recognize the importance of alignment. Indeed, CMS specifically notes that that the “QRS measure set should...align, to the maximum extent possible, with priority measures currently implemented in federal, state and private sector programs to minimize QHP issuer burden.” We also appreciate that the agency proposes to select measures based on criteria partially adapted from two multi-stakeholder processes

currently used to identify measures for federal programs – the NQF measure endorsement process and the MAP. The NQF endorsement process uses multiple stakeholders to review measures against rigorous evaluation criteria. Endorsed measures produce reliable and valid results, are usable for accountability programs, and are feasible to collect and report. The MAP provides input on which measures to use in federal payment and reporting programs in advance of formal rule-making. The MAP’s evaluation criteria for measure sets provide helpful guidance on assessing the alignment of a measure set with health care system-wide priorities.

However, we believe CMS should strengthen its approach to aligning the QRS with other federal quality measurement programs in two ways. First, the agency should submit the list of measures it is considering for the QRS as part of the MAP’s annual pre-rulemaking process. The AHA strongly supports the premise of the MAP’s work. That is, improvement in our nation’s health care system can be catalyzed by selecting a limited number of rigorous quality measures in federal programs focused on improvement areas that a broad array of stakeholders believe to be important. CMS recently engaged a task force of the MAP to assess its proposed QRS framework and initial set of measures. While we commend CMS for this one-time engagement of the MAP, the MAP’s pre-rulemaking process facilitates a regular, multi-stakeholder analysis of whether the measures in the QRS are measuring priorities consistent with other federal programs.

Second, the QRS should only use those measures that are NQF-endorsed for assessing performance at the health plan level. NQF endorsement is a valuable signal to the field that a measure is scientifically rigorous, and will accurately portray the performance of the entity being measured. The “level of analysis” (e.g., acute care hospital, physician office, health plan) at which a measure is NQF-endorsed also is critical because health care providers and payers along the care continuum contribute to an overall improvement goal in different ways. For example, while a hospital’s role in improving cardiovascular care outcomes is to provide acute interventions (e.g., surgery), a health plan would likely focus its efforts on helping patients get screened for risk factors for cardiovascular diseases. **Thus, while the overall quality improvement goals may be the same, the measures used for each entity may need to differ to account for the different roles played by each in the delivery system.**

There also are critical differences in the types of data available to each entity, as well as data collection processes. For example, a health plan may have access to a patient’s administrative records over a longer period of time than an outpatient clinic, and may be better equipped to assess the time intervals between disease screenings. We appreciate that most (76 percent) of the 42 measures in the proposed QRS measure set for adults are NQF-endorsed for health plans. **Nevertheless, we recommend that CMS remove the non NQF-endorsed measures from the measure set to ensure that the QRS reports accurate and valid results.**

QRS NEEDS MORE MEANINGFUL MEASURES OF PATIENT ACCESS AND AFFORDABILITY

The majority of the proposed measures for the QRS assess various aspects of clinical care delivery and patient experience, with a focus on whether plan beneficiaries receive screenings for diseases like cancer, diabetes and cardiovascular conditions. The AHA certainly agrees that

measures in those areas provide valuable insight on the quality of prevention and early intervention consumers may receive from a health plan.

However, in choosing insurance, many patients are concerned about whether sophisticated or expensive services will be available when they need them. Consumers worry that health plans' financial interests are often at odds with policies that allow easy and quick access to expensive and needed services. However, the QRS includes only a few measures that assess the role health plans play in linking patients to needed services, and ensuring that patients have access to those services. The measures that are currently proposed for the "access" domain of the QRS also provide fairly vague information, and may not provide patients with meaningful information. For example, CMS has included two items from the health plan Consumer Assessment of Health Providers and Systems (CAHPS) survey – getting care quickly and getting needed care. These two items are composites of several survey items on the health plan CAHPS survey¹, including:

- Got care for illness/injury as soon as needed
- Got appointment with specialists as soon as needed
- How often was it easy to get necessary care, tests or treatments

We absolutely agree that getting the patient-reported perception of access provides valuable insight. However, these CAHPS items provide little information about how long a patient may actually have to wait to get needed services. **Thus, we also encourage the agency to explore the inclusion of complementary measures of access with more explicit information, such as wait times to the first appointment with a primary care physician or specialist, and wait times for major elective surgeries (e.g., bypass surgery).** These types of measures would provide patients with more meaningful insight into whether the health plan provides adequate access to needed care within a given timeframe.

Similarly, the AHA urges CMS to consider including in the QRS more meaningful information on affordability, such as total costs and out-of-pocket costs for services (e.g., deductibles, copayments and coinsurance). The agency's proposed measures of "efficiency and affordability" include three measures of the appropriate use of screening tests, as well as two measures of "relative resource use." The screening use measures provide only partial insight into how efficiently a health plan uses resources. Indeed, the measures must be carefully risk-adjusted to ensure that health plans do not score worse on the measures simply because their patient populations have a higher need for such screenings. Moreover, we do not support the use of the relative resource use at this time. While we agree that episode-based cost measures have merit in some contexts, we believe additional information is needed in order to fully understand the intended purpose and use of the measures proposed for the QRS.

Consumers have greater familiarity with and understanding of information on total and out-of-pocket insurance costs. Indeed, such information is a critical first step to considering the affordability of a QHP. We also encourage health plans to further develop tools that are tied directly to the individual benefit design and include information on applicable copayment, coinsurance, and or deductible information. Such tools should assist consumers in identifying

¹ See https://cahps.ahrq.gov/surveys-guidance/docs/2150_Overview_50_Survey.pdf

any impact that selection of an out-of-network provider is expected to have on the patient's responsibility for payment.

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/

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