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George Isham, M.D., and Elizabeth McGlynn, Ph.D.
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, December 2014***

Dear Drs. Isham and McGlynn:

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 Measure Applications Partnership's (MAP) December 2014 pre-rulemaking report.

**The AHA continues to believe the MAP process can be essential to achieving broad scale improvements in healthcare, but as we wrote to you in** December 2014**, the most important opportunity for the MAP to foster broad quality improvement is through the identification of a specific list of high priority national topics for improvement. Once these are identified, the Coordinating Committee can task the Workgroups with bringing forward measures for inclusion in national programs that both track progress toward achieving the goals and monitor whether each sector of the health care system is doing what it should to contribute toward the accomplishment of the overarching goal.** Such an approach should use a small number of reliable, accurate and care setting-appropriate measures to address the most important areas for improvement. Our letter offered 11 priority measurement topics where AHA members suggest measurement programs should focus in the short term. We now provide additional recommendations on ways to optimize the use of the MAP process to encourage greater focus and alignment across federal programs. We also comment on several specific measures included on this year's Measures Under Consideration (MUC) list by the Centers for Medicare & Medicaid Services (CMS).

We appreciate that the MAP has been focused on continually improving the efficiency and effectiveness of its processes. The changes implemented as part of this year's process – that is, the use of structured consent calendars during the meeting, and earlier opportunities for public comment – are commendable. They greatly improved the clarity of decision-making and increased the opportunity for stakeholder input. However, these changes do not help the MAP

make a determination of whether measures address a high-priority area. We believe more far-reaching process changes are necessary for the MAP to foster the alignment and focus in federal measurement programs that is so urgently needed.

## USING THE MAP PROCESS FOR FOCUS AND ALIGNMENT

We are concerned that important opportunities to improve care are being lost. The sheer volume of reporting requirements has become overwhelming and confusing. As noted in our December letter, there are six times more measures in the hospital inpatient quality reporting (IQR) program in fiscal year (FY) 2016 than there were at the program's inception in FY 2005. To add to the confusion, private payers and state regulators have adopted their own reporting requirements. While some of these efforts sound as if they use the same measures, the measure specifications are different. This results in an overwhelming set of discordant and conflicting data about provider performance.

The MAP's multi-stakeholder composition and statutory mandate to review nearly all quality measures being considered for federal programs afford a unique opportunity to look across programs and measures, identifying the entire health care delivery system's best opportunities for improvement and measurement. But the lack of specific, actionable national priorities also makes it hard for the MAP to identify and recommend measures that can lead to substantial improvements in patient care. For example, this year's MUC list included more than 100 measures for the Medicare Shared Savings Program (MSSP). The MSSP measures addressed topics ranging from Medicare Spending per Beneficiary, to screening for HIV patients, to whether certain steps were taken in pelvic prolapse repair procedures. CMS provided a rationale for each individual measure, but did not explain whether or how each measure would contribute to a specific national goal for improvement, such as premature mortality from heart disease or reducing healthcare acquired infections. As a result, the work groups were left debating the technical merits of each measure, not whether the measure would effectively promote achievement of the desired improvement.

**The AHA urges the MAP to work with its federal partners and other stakeholders to identify five to 10 tightly scoped, actionable priority goals for improvement, and strong measures appropriate to each care setting can be used to track performance and drive improvement for patients.** The MAP should construct this list of priorities early enough in the year to allow CMS to use it to construct the MUC list.

To provide a starting point for discussion, the MAP could make use of the priority areas we provided in our December comment letter and use the following approach and timeline:

| Timeframe | Suggested MAP Activities |
|---|---|
| February – March | • NQF staff discuss with CMS and other federal stakeholders their priorities for improvement and measurement<br>• Invite comments and suggestions from other stakeholders on priorities<br>• Develop a draft list of priorities for discussion |
| April - May | • Convene the MAP Coordinating Committee to review a priorities list<br>• Conduct public comment on the proposed priority list |
| June | • Consult with MAP Coordinating Committee to determine whether changes to the priority list are needed based on the comments<br>• Issue final priority list |
| December – January | • Assess which measures should be recommended to HHS for use in various federal programs to support achievement of the identified goals |

The existence of a common set of goals would help the MAP articulate a much clearer concept than it can now of how the work of all providers could come together to achieve the identified goal. 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 health care resources are under intense scrutiny, an aligned, focused approach to quality measurement and pay-for-performance programs can ensure that such programs include measures targeted at areas that will drive the most important and meaningful improvements across the health care delivery system.

## THE IMPORTANCE OF SOCIODEMOGRAPHIC ADJUSTMENT

**The AHA urges the MAP not to recommend outcome measures – such as readmissions, potentially avoidable admissions, and cost and resource use – for programs unless the measure has been assessed for the impact of sociodemographic adjustment, and adjustments are implemented, if warranted.** The AHA is pleased that several such measures were supported by the MAP on the condition that they be included in NQF's "trial period" for sociodemographic adjustment. We believe this is an important first step towards ensuring that providers do not suffer reputational or financial harm from poor performance on quality measures due to community factors beyond their control.

Indeed, failing to adjust measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that

contribute to worse outcomes. Hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, as a growing body of research demonstrates, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying those other factors and helping all interested stakeholders understand their role in poor outcomes, then the nation's ability to improve care and eliminate disparities will be diminished.

We look forward to continuing our engagement with the MAP, and thank you for the opportunity to comment. If you have any questions, please feel free to contact me or Akin Demehin, senior associate director of policy, at (202) 626-2365 or ademehin@aha.org.

Sincerely,

/s/

Nancy Foster
Vice President Quality and Patient Safety Policy