American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

January 13, 2017

Charles N. Kahn and Harold Pincus, M.D.
Co-chairs, Measure Applications Partnership
c/o National Quality Forum
1030 15th Street, N.W., Suite 800
Washington, DC 20005

RE: Measure Applications Partnership Pre-Rulemaking Draft Recommendations, December 2016

Dear Mr. Kahn and Dr. Pincus:

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 2016 pre-rulemaking draft recommendations. This letter provides overarching comments about the MAP process; we commented separately on specific measures under review using the National Quality Forum's (NQF) online commenting tool.

The AHA continues to believe the MAP's best opportunity to promote broad improvement in health care is to use a streamlined set of actionable quality improvement priorities to identify "measures that matter" the most to optimizing outcomes for patients and communities.

By leveraging its multi-stakeholder composition and mandate to review measures across nearly all of the Centers for Medicare & Medicaid Services' (CMS) programs, the MAP is in the unique position to accelerate improvement by recommending a limited number of effective, reliable and care setting-appropriate measures. Currently, the field is inundated with uncoordinated measure requirements from a variety of public and private payers. The AHA stands ready to work with the MAP to identify system-wide priorities upon which the MAP could evaluate measures and CMS could identify potential future measures. Using input from hospital leaders, the AHA has identified 11 quality measurement priority areas (Attachment A) for hospitals. Those areas also are well-aligned with the 15 core measure areas for the nation's health care system identified in the National Academy of Medicine's (NAM) *Vital Signs* report. In our Jan. 12, 2016 letter, the AHA recommended the MAP use these areas to evaluate measures and quality improvement. A mapping of AHA hospital measurement priorities to NAM core measures is provided in Attachment B.

Unfortunately, the MAP process has yet to realize the promise of identifying "measures that matter." As a result, the MAP considers and often supports an excessive number of measures unmoored to any priority areas and lacking evidence demonstrating that their use will enhance the quality of care. Below the AHA recommends additional steps the MAP should take to ensure the measures it recommends most effectively enhance quality improvement efforts for patients.

The AHA urges the MAP not to recommend any new measures that duplicate data efforts or data produced by existing processes. Many of the measures on this year's Measures under Consideration (MUC) list would duplicate efforts or data produced by existing processes. For example, several measures involve performing an additional examination or screening upon admission to evaluate a specific condition, such as malnutrition or alcohol/substance abuse. Providers already perform tests and screenings at intake that provide more than enough information to make judgments on whether a patient suffers from those specific conditions. The additional screening mandated by the measure could be entirely inconsistent with existing workflow, thereby increasing the workload without improving the value to the patient.

Moreover, **these process measures often do no more than assess whether a provider completed a task.** The measures do not demonstrate a strong connection between the process step taken and improved patient outcomes. This is problematic for two reasons. First, process measures unlinked to better outcomes can drive provider efforts towards narrow interventions rather than holistic care. For example, a malnutrition screening measure could replace the existing and more robust intake process for an overworked provider. If it is easier to perform a cursory malnutrition screening as required by the measure, there is no need to perform other important tests and screenings upon admission that do not contribute to quality scores.

Second, these process measures add a significant number of tasks; even if they are not duplicative, process measures often entail substantial effort to collect. Therefore, **the AHA suggests that the MAP should only recommend process measures if they show a strong correlation between the measured intervention and outcomes of interest.**

In addition, the AHA is concerned that many measures have been insufficiently tested and validated to ensure that they will produce useful and accurate data at the relevant sites of care. Without that information, it is very challenging to even suggest something be "refined and resubmitted" because there is not enough information to know whether the measure can actually work in its current form. For example, certain measures require post-admission follow-up visits with patients, which the AHA acknowledges are important parts of the care continuum. However, the measures as they were specified for the MAP were tested at the health plan level, not for acute care hospitals.

Many other measures discussed at the MAP workgroup meetings did not have NQF endorsement at the time, or explicitly did not meet the evidentiary standards required. Untested or non-evidence-based measures are inappropriate for consideration by the MAP; therefore, **the AHA suggests that CMS only include fully tested and NQF-endorsed measures on the MUC list.** Putting forth a concept of a measure rather than a fully developed, specified and tested measure for MAP review is inconsistent with the congressional intent that created the MAP. We appreciate CMS's interest in obtaining the input of the MAP on measure concepts or ideas;

however, we believe that task should not occur simultaneously with the review of measures being proposed for inclusion in a program.

Furthermore, the AHA cautions the MAP against a hierarchical preference for electronic clinical quality measures (eCQMs). The AHA continues to be concerned about the burden of reporting eCQMs. During the MAP hospital workgroup discussions, many participants appeared to suggest that eCQMs are unequivocally easier to collect and report than chart-abstracted measures. While theoretically these measures should reduce the effort entailed in manual chart abstraction, **introducing additional or converting existing measures to be eCQMs incorrectly assumes that the measures work as intended and that all electronic health record (EHR) products support the reporting of those measures.** A 2013 AHA study of the experiences of hospitals in reporting eCQMs revealed that measure specifications are often not truly "plug and play," and hospitals must employ extensive workarounds to obtain measure results. Moreover, hospitals often obtain measure results from eCQMs that do not correlate with the results from the gold standard chart abstracted measures. In addition, many of the quality reporting programs discussed at the MAP workgroup involved sites of care that are not required to or typically do not have fully interoperable EHR systems (e.g., freestanding inpatient psychiatric facilities or end-stage renal disease facilities). Because of questions concerning the feasibility and accuracy of eCQMs, the AHA urges restraint in adding or converting measures into eCQMs.

Finally, this year's MAP considered measures regarding major public health issues such as opioid abuse and malnutrition. While the AHA acknowledges the importance of treating patients suffering from these maladies, **the measures proposed provided virtually no data demonstrating the connection between the measure and improved patient outcomes.** Some measures even evaluated hospital performance based on community-level outcomes without a mechanism to accurately attribute the health of the patient population to hospital efforts. For example, a community smoking prevalence measure is a great measure for a public health department or Medicaid program. But given the multitude of factors contributing to smoking rates, it would be more appropriate to assess hospitals on their efforts to improve on the outcome, not on the overall outcome. **The AHA urges CMS not to include such measures for consideration unless there is evidence linking the intervention to improved outcomes.**

Thank you for the opportunity to comment. Please contact me if you have questions or feel free to have a member of your team contact Caitlin Gillooley, associate director of policy, at cgillooley@aha.org or (202) 626-2267.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Attachment A

AHA Identified Priority Measurement Areas

1. Patient Safety Outcomes
   - Harm Rates
   - Infection Rates
   - Medication Errors
2. Readmission Rates
3. Risk Adjusted Mortality
4. Effective Patient Transitions
5. Diabetes Control
6. Obesity
7. Adherence to Guidelines for Commonly Overused Procedures
8. End of Life Care According to Preferences
9. Cost per Case or Episode of Care
10. Behavioral Health
11. Patient Experience of Care / Patient Reported Outcomes of Care

Attachment B

Mapping of AHA Hospital Measure Priority Areas to the National Academy of Medicine's *Vital Signs* Core Measure Areas

Life Expectancy ***Risk Adjusted Mortality (#3)***
Wellbeing ***Diabetes Control (#5)***
Overweight & Obesity ***Obesity (#6)***
Addictive Behavior ***Behavioral Health (#10)***
Unintended Pregnancy
Healthy Communities
Preventive Services
Care Access ***Readmission Rates*** ***Effective Patient Transitions***
Patient Safety ***Patient Safety Outcomes (#1)*** • ***Harm Rates*** • ***Infection Rates*** • ***Medication Errors***
Evidence-based Care ***Adherence to Guidelines for Commonly Overused Procedures (#7)***
Care Matched to Patient Goals ***End of Life Preferences (#8)***
Personal Spending
Population Spending ***Cost Per Case of Episode (#9)***
Individual Engagement ***Patient Experience of Care/Patient-Reported Outcomes (#11)***
Community Engagement

Blue = NAM Core Measure Area
Red = AHA Priority Measure