

March 3, 2011

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Coordinator of the Advisory Council Subcommittee
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

File Code: CMS-2420-NC: Medicaid Program: Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults

Dear Dr. Wilson:

The Consumer-Purchaser Disclosure Project, representing consumer, labor union, and purchaser interests, is pleased to have the opportunity to comment on the proposed core set of quality measures for use in assessing care provided to adults enrolled in Medicaid. We commend AHRQ and CMS' continued commitment to the expansion of quality data collection and public reporting, and appreciate their efforts in fostering increased transparency and promoting the use of measurement to improve quality throughout our health care system.

We believe that quality measurement is an essential component of transforming the health care system into one that delivers appropriate, high quality, efficient, equitable, and patient-centered care. Public accountability has been sorely lacking in Medicaid, particularly for adult beneficiaries under age 65. Members of the Disclosure Project are committed to using measurement to improve quality and ensure that all Americans have access to publicly reported health care performance information. We support CMS' continued efforts to promote and foster both increased transparency, as well as a market that recognizes and rewards quality. We believe that all consumers – regardless of whether their care is paid for by the private or public sector – should be able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency, and that by reporting on the quality of care, providers and health plans are held accountable for improving the care they deliver. It is our hope that by creating a voluntary quality reporting program for adult Medicaid enrollees, and establishing a standardized reporting format for these measures, this initiative will foster increased transparency and promote a Medicaid market that recognizes the critical importance of quality and value.

Our comments focus on the following:

- The criteria used to determine the proposed initial core set
- Specific measures in the proposed core set
- Suggestions for enhancing the core set to support efficient implementation across all Medicaid programs, providers, and enrollees
- Fulfilling the program's goal through improved measure development

Determination of Proposed Core Measure Set

As outlined in the request for comment, the subcommittee used the following criteria to determine which measures would be in the core set: 1) scientific acceptability of measure properties; 2) feasibility of use by Medicaid; and 3) importance to Medicaid programs. While these are certainly important and reflect the consensus development process evaluation criteria which we support at the National Quality Forum, we

are concerned about the lack of weight given to whether the measures would provide meaningful information 1) to Medicaid beneficiaries in the areas of outcomes, functional status, care coordination and transitions, and patient experience; and 2) on conditions and/or care processes for which there is documented variation across the country in terms of quality and/or cost. We believe that to the extent possible, this program should focus on not just the criteria identified by the subcommittee, but also on the additional suggested criteria, in order to build this program from the beginning with an eye toward measuring and improving outcomes and reducing cost increases.

Proposed Core Measure Set

We strongly encourage AHRQ to reconsider both the volume and content of the core measure set. The set as proposed is heavily-laden with measures that we do not feel meet the criteria described above. In addition, we feel that the overall reporting burden and cost to states – as well as to health plans and providers – will be overwhelming particularly in this time of extreme budgetary distress. For many states, participation in this program will represent a move from collecting no defined quality measures to assess care provided to Medicaid and CHIP beneficiaries, to collecting a high volume of data. This is especially true for states that wish to also participate in the CHIPRA quality measurement activity. Given the voluntary nature of this program, we fear that if it is perceived as too burdensome, states will pick and choose which measure to implement, rather than report on the core set as a whole. This will make it difficult to collect and assess comparable data across the states, which would defeat one of the goals of the program. Below, we offer concrete suggestions on which measures we would encourage you to eliminate from the program. In our next section, we suggest additional measures that should be added to the program, in order to fill gaps in the areas of perinatal care, imaging, and geriatric care.

Prevention and Health Promotion

We support measures 1 through 7, which focus on critical screenings for adult weight, breast cancer, cervical cancer, alcohol misuse, and clinical depression, as well as flu shots for high-risk populations, and medical assistance with smoking cessation. Regarding the 13 AHRQ Preventive Quality Indicators (PQIs), **we think the core set should include only the following:**

- PQI 05: Chronic Obstructive Pulmonary Disease
- PQI 08: Congestive Heart Failure
- PQI 11: Bacterial Pneumonia
- PQI 12: Urinary Tract Infection Rate
- PQI 15: Adult Asthma

According to data released by AHRQ in December 2010, bacterial pneumonia, urinary tract infection, and adult asthma had the highest rates of preventive hospital admission among those ages 18-39 (with even higher rates in that population among women). For adults age 40-64, the highest rates of preventive hospital admissions occurred for bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and adult asthma. Thus, in an effort to focus on the areas where we are seeing highest need for quality data, and to reduce the volume of the proposed core set, we suggest AHRQ and CMS target these five conditions for the first year of the program, and eliminate the other eight PQIs from the core set.

Management of Acute Conditions

In the areas of acute condition management, **we support the inclusion of the following measures**, which we believe will provide important information to states and consumers on overuse, as well as on care coordination/transitions:

- 22: Use of Imaging Studies for Low Back Pain
- 24: Follow-up After Hospitalization for Mental Illness
- 25: Appropriate Use of Antenatal Steroids
- 26: Elective delivery prior to 39 completed weeks gestation,
- 27: Timely transition of Transition record from inpatient discharges to home/self-care or any other site of care
- 28: Transition Record with Specified Elements Received by Discharged Patients (inpatient discharges to home/self-care or any other site of care)

We encourage AHRQ to remove measure 23: Hospital-Based Inpatient Psychiatric Services (HBIPS) 2 hours of physical restraint use. We do not believe that this will add value to the program, and feel that the other mental health measures proposed would be more productive to providing states and consumers with meaningful information.

Management of Chronic Conditions

Appropriate management of care for patients with chronic, and in particular, multiple chronic conditions, is key to improving outcomes and containing health care costs. We believe that if the health care system can provide high-quality, effective, efficient, patient-centered care for the most vulnerable patients with chronic conditions, then it can provide that level of care for all consumers. Thus we are pleased to see a category devoted to this population. However, we are disappointed that the measures proposed by AHRQ in this area are primarily process measures, and do not include any significant number of outcome measures. While quantifying the number of times a process was performed or the number of times a patient utilized care may provide a rough indicator of access, it tells nothing about the effectiveness of that care.

The key to identifying and addressing improvements in delivery of high quality care is knowing what the outcomes of these processes were. For example, Measure 33 assesses whether patients between the ages of 18 and 75 received a complete lipid profile, while Measure 34 assesses whether this population received Hemoglobin A1(c) testing. Neither of these indicates whether cholesterol or blood sugar levels were controlled to within acceptable ranges. There are NQF measures that do assess these intermediate outcomes that should be considered for inclusion in the core set in lieu of these. These include NQF Measure 0059: Hemoglobin A1c Management; NQF Measure 0064: Diabetes Measure Pair on Lipid Management; and NQF Measures 0061 and 0073, both related to blood pressure management. In light of these, we urge AHRQ to **consider dropping the following measures from the core set:**

- 29: Persistence of Beta Blocker Treatment After Heart Attack
- 31: Coronary Artery Disease: Drug Therapy for Lowering LDL Cholesterol
- 32: Comprehensive Ischemic Vascular Disease Care: Complete Lipid Profile and LDL-C Control Rates
- 33: Diabetes: Lipid Profile
- 34: Comprehensive Diabetes Care: Hemoglobin A1c Testing

In regard to Measures 38-42, all related to Bi-polar disorder or Schizophrenia, we agree with AHRQ that there is a critical need for better information on the quality of mental health care that is provided to all consumers. We know that for the adult Medicaid population, hospital costs directly related to unmet mental health needs make up a significant percentage of states' Medicaid budget and are extremely important to measure. We ask for clarification, however, on why the ARHQ special committee selected the proposed RAND measures, rather than proposing the following NQF-endorsed measures which address almost parallel concerns as Measures 38-42:

- 0544: Use and Adherence to Antipsychotics Among Members with Schizophrenia
- 0003: Bipolar Disorder: Assessment for Diabetes
- 0552 and 0560: Both look at patients discharged with multiple antipsychotic medications

Given the similarities between the RAND measures and the NQF-endorsed measures, we ask for clarification on: a) the difference in unit of analysis for the RAND and NQF measures; b) whether there are plans to harmonize competing measures for clarity; and c) whether AHRQ is planning to compare the similar measures to determine "best in class," given that the RAND measures are in use by the Veteran's Health Administration

Family Experience of Care Measures

We support the inclusion of the adult version of the CAHPS 4.0 version of the health plan survey, and the supplemental items required by NCQA for plans it accredits. We recommend, however, that AHRQ and CMS, together with its special subcommittee, consider granting flexibility regarding how states implement this measure, given the differences that may arise among states without significant HMO penetration (i.e. states where the Medicaid program itself is the health plan), and states in which a majority of the Medicaid beneficiaries are enrolled in a capitated plan. For those states with high capitation plan saturation, we suggest they be allowed to report their CAHPS data as an average of scores across all plans, with appropriate weighting determined by plan enrollment.

In future years of the program, we would also urge that the individual clinician and group CAHPS (C/G CAHPS) tool be considered for inclusion in the program. Collection and public reporting of patients' experiences of care at the individual and group practice provider levels will provide beneficiaries with important information for use in selecting their physicians.

Availability

We encourage AHRQ and CMS to **remove Measures 47, 48 and 50**. These measures merely quantify utilization of care, and are very weak indicators of appropriate access to care. However, we do support the inclusion of Measure 51, the postpartum visit rate, as it can be a useful indicator of poor post-delivery follow-up. As noted previously in our comments, however, we encourage AHRQ to take a leadership role in the development of measures of utilization that include measuring the quality of those post-partum visits for inclusion in future iterations of this core set.

Suggestions for Strengthening the Core Set

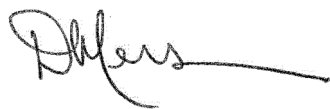
Based on the suggestions above, the core set would now comprise 33 measures, which we believe is closer to a manageable number for the program's first year. However, we also strongly recommend adding the following to fill gaps that we have identified in measures relevant to perinatal care, geriatric care, and the field of overuse/imaging:

- Exclusive Breastfeeding at Hospital Discharge: Evidence suggests that exclusive breastfeeding is the optimal way to feed nearly all infants for the first six months of life. Breastfeeding also has valuable health benefits for the mother. Many women, however, do not receive adequate information, encouragement, or support for breastfeeding. It is critical to the well-being of both the new mothers and their infants that hospital staff vigorously encourage and support women in exclusively breastfeeding their infants, and we see this as a critical measure of perinatal care for the Medicaid adult population. This measure was endorsed by NQF in 2008.
- The Medicare Health Outcomes Survey: The Medicare Health Outcomes Survey (HOS) is the first national survey to measure the quality of life and functional health status of Medicare beneficiaries enrolled in managed care, and has resulted in significant improvements related to outcomes and functional status for these beneficiaries. We believe that the core measure set as currently proposed is lacking in measures that assess quality of care for older adults living in the community who require ongoing long-term care to manage their serious, often multiple, chronic illness, and encourage AHRQ and CMS to investigate the potential for the HOS to be applied to the Medicaid population.
- Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery: Research indicates consistent overuse of cardiac imaging as part of the pre-operative evaluation process for patients who are undergoing low-risk, *non-cardiac* surgery, resulting in unnecessary high costs as well as radiation-related patient safety concerns. We believe this measure will provide valuable information to states and contribute to the field's identification of overuse of cardiac imaging in this population.

Developing Measures to Fill Identified Gaps

The mandate for this program includes a fund to develop, test and validate innovative measures to improve efforts to collect and publicly report quality metrics on the adult Medicaid population. We strongly urge AHRQ and CMS to take a leadership role in developing measures to address the gaps identified in this letter, including measures of provider utilization that indicate whether high quality care was provided, as well as patient-reported measures of outcomes, functional status, care coordination, and care transitions.

On behalf of consumers and purchasers across the country, we thank you for your efforts and your responsiveness to our comments. If you have any questions, please contact either of the Disclosure Project's co-chairs, Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families



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