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March 1, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

RE: Quality Measure Development Plan

Dear Acting Administrator Slavitt:

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) draft Quality Measure Development Plan (MDP): Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). AARP is pleased to submit comments regarding the strategic framework for quality measures development, which is required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as the agency moves towards implementing MIPS and APMs.

AARP applauds and supports CMS in its transition from volume-based to value-based payments. AARP also supports many of the key elements contained in this draft MDP. We agree that the MDP should prioritize the development of measures in gap areas which have the greatest potential to improve patient care and provide meaningful information to clinicians and consumers. The MDP should also prioritize measures which are cross-cutting and support alignment of quality measures across public and private sectors.

AARP
Real Possibilities

Measures are ultimately intended to improve patient care; consequently, it is critically important that consumer and patient groups be part of a multi-stakeholder process to select, develop, and endorse future measures. AARP also urges CMS to select measures for development and prioritization that raise the bar on clinical care and support population health management. Finally, CMS should be watchful for potential unintended negative consequences, such as being mindful that a focus on efficiency and cost reduction could potentially lead to stinting of care.

General Principles (page 19)

AARP supports the principles outlined in the draft MDP to guide the development of quality measures. We offer these additional elements to strengthen them:

- In addition to focusing on outcomes, safety, patient experience, care coordination, and appropriate use, the principles should also focus on (a) reducing diagnostic errors; (b) validated process of care measures that have a known relationship to outcomes; (c) transitions between settings; and (d) caregivers' experiences.
- CMS should monitor disparities in access to care, in addition to disparities in the delivery of care, and unintended consequences.
- Finally, the last principle should reflect a partnership—rather than a paternalistic relationship—with consumers, patients, and their family caregivers. We suggest this alternative language: “Engage patients, caregivers, and consumers in every step of the care process to ensure support and respect for individual goals and preferences.”

Evidence Base for Non-Endorsed Measures (page 29)

For measures not endorsed by a consensus-based entity, we urge CMS to require multi-stakeholder input in the review process, including the input of consumers, patients, and caregivers.

We also urge CMS to not limit a “well-crafted business case for a measure concept” to lives saved and costs saved. Patients, families, and consumers value additional factors, such as quality of life, functional status, side effects, treatment burden, and patient preferences. Quality measures should take these factors into account, as well.

Clinical Care (page 31)

We applaud CMS for adopting a collaborative approach to developing measures of clinical care in areas where there are important gaps in performance. However, we urge CMS to include a broad range of stakeholders in this effort, not just specialty groups and associations. In particular, patients and their caregivers should be directly involved in the measure development process and given the opportunity to contribute their views

on measurement priorities, desired outcomes, and quality targets. Including patients and their caregivers in the measure development process will ensure that the measures under consideration are important to patients, caregivers, and providers.

We are pleased to see the MDP's inclusion of providers' diagnostic skills among the measure development priorities for MIPS and APMs. However, we encourage CMS to move beyond measures simply evaluating providers' diagnostic skills to measures of providers' diagnostic accuracy. Diagnostic errors are arguably one of the most important safety hazards for patients. Measuring providers' diagnostic accuracy is key to preventing harm to patients from diagnostic errors.

Safety (page 31)

AARP supports the development of safety measures on the proposed topics (medication errors, complications from procedures, and all-cause harm in outpatient and ambulatory care settings). We recommend development of safety measures in additional areas, including diagnostic errors and avoidable hospitalizations (that is, hospitalizations for ambulatory-care sensitive conditions). We also suggest CMS explore development of measures to identify situations in which patients (or caregivers) are expected to conduct health management tasks that they are unable or unwilling to perform, or for which they have not received adequate information, training, or support.

Care Coordination (page 32)

AARP views appropriate support for patients as they transition from one site of care to home or another site to be an essential component of a high performing health system. Therefore, under the Care Coordination quality domain, AARP asks that CMS specifically designate "care transitions" as a sub-domain, with its own specified set of measures.

Patient and Caregiver Experience (page 33)

We strongly support the continuing development of surveys of patient and caregiver experiences, including the development of specialty-specific surveys. Efforts should focus on collecting data to support experience measures that indicate changes providers could make to improve care for patients. They should also focus on measures which are valuable to patients and families in decision-making, such as in choosing providers.

The low response rate to Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and the long lag-time in receiving feedback, impede the ability of providers, consumers, and the Medicare program to realize the full potential of patient- and caregiver-reported information. We urge CMS to explore ways to improve the data collection and reporting processes.

AARP recommends CMS include additional questions in CAHPS surveys which reflect areas of importance to patients and families. For example, the Cultural Competence supplemental item set includes questions assessing: whether a provider spoke too fast or used words a patient didn't understand; whether the patient felt he or she was treated unfairly because of race, ethnicity, or perceived English-language ability; and whether, if necessary, an interpreter was provided and how the patient rates the interpreter.

We also support continuing research on how to combine patient experience scores with narrative questions, and how to report narrative findings in ways that are valid and have meaning for providers, patients, and families.

Engaging Patients in the Measure Development Process (page 47)

We applaud CMS for requiring measure developers to include patients and caregivers in the measure development process and for pursuing ways to overcome the challenges to patient and caregiver involvement.

In addition to including patients and caregivers on measure development panels, we urge CMS to encourage measure developers to also use additional methods to obtain the perspectives of patients and caregivers. For example, focus groups with patients and caregivers could provide valuable information to developers about what matters to patients, what patients' priorities are, and whether measures are meaningful and useful to consumers. This information could help measure developers set priorities in choosing measures to develop and, later in the process, help them refine measures and how they are reported so they are useful to consumers.

Reducing Provider Burden of Data Collection for Measure Reporting (page 47)

AARP supports efforts to reduce the burden of data collection for measure reporting. AARP supports many elements of CMS' strategic approach to achieving this goal, such as collecting data that are part of the existing clinical workflow and collecting data directly from the patient or caregiver. However, we urge CMS to ensure that these alternative approaches do not compromise the ultimate aim of the measure development process, which is to develop and implement measures that have the greatest potential to improve patient care and provide useful information to clinicians and consumers.

AARP also commends CMS in its effort to work with private payers to develop core measures that can be used by all payers. We urge CMS to include patients' and consumers' perspectives and to work with consumers and patient groups, in addition to working with private payers, as it develops core quality measures.

Developing PROMS and Appropriate Use Measures (page 50)

AARP supports measures that are likely to drive improvements in the quality and efficiency of care, without compromising either, yet we remain concerned about

measures that could discourage access to appropriate care. We also support efforts to reduce use of overused, low-value tests and procedures (when supported by robust evidence), reduce waste in the health care system, and improve quality and safety of care. Measures of low value services would probably require the use of clinical data, though, and might not be feasible using currently available claims data.

Population-based payment models, such as capitated payment for enrollees in Medicare Advantage plans, create incentives to encourage efficiency. CMS should be watchful that these measures not lead to unintended consequences, such as encouraging providers to stint on quality of care or limit access to appropriate care in an effort to capture savings or increase profit. In a fee-for-service environment, measures of resource use should be reported alongside quality of care measures to ensure that providers do not stint on care in order to capture savings. CMS should likewise watch for potential unintended consequences with the use of such measures.

We support the development of more direct measures of appropriate use, such as indicators of diagnostic accuracy and clinical guidelines (as described in Clinical Practice Guidelines, page 27). These measures should be carefully crafted and targeted to assure that they do not discourage access to appropriate care, and should be developed in close consultation with stakeholders, including patients and consumers, through the National Quality Forum and other similar forums.

Patient-Reported Outcome Measures (PROMs) could be collected from patients using a web-based mechanism, such as “survey monkey.” This approach would minimize administrative burden to providers.

AARP appreciates this opportunity to provide comments on the Quality Measure Development Plan. If you have any questions, please feel free to contact Andrew Scholnick of our Government Affairs staff, at ascholnick@aarp.org or 202-434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a stylized flourish at the end.

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs