American Heart Association | American Stroke Association

April 28, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Submitted via email to: Marketplace_Quality@cms.hhs.gov

**RE: QRS Scoring Specification Comments**

To Whom It May Concern:

On behalf of the American Heart Association (AHA), including the American Stroke Association (ASA) and over 22 million AHA and ASA volunteers and supporters, we appreciate the opportunity to submit our comments to the Centers for Medicare and Medicaid Services (CMS) on the Quality Rating System (QRS) Scoring Specifications.

Since 1924, AHA has dedicated itself to reducing disability and death from cardiovascular disease (CVD) and stroke—the #1 and #4 leading causes of death in the United States—through research, education, community based programs, and advocacy. To this end, the AHA is committed to improving the cardiovascular health of all Americans by 20 percent while reducing deaths from CVD and stroke by 20 percent by the year 2020.

One of the approaches AHA uses to achieve its mission is to continually raise the bar on quality patient care by advocating for and creating systems, programs, and partnerships that ensure the effective translation of evidence-based medical guidelines into standard patient care. Quality measures are one element of this approach and we believe that the measures used by the QRS program create a potentially powerful lever to promote the delivery of health quality care.

The AHA/ASA submitted comments on CMS' November notice and we reiterate those comments here, as well as make a few additional recommendations. In summary, these comments are:

- Overall appreciation for the focus on cardiovascular care in the QRS measure set

- Continued concern with CMS' use of non-endorsed measures which do not allow for the examination of their measure specifications and suggestions for existing NQF-endorsed measures with similar intentions
- Continued desire to see additional medication adherence measures incorporated into QRS
- Request for inclusion of a cardiac rehabilitation referral measure in the QRS measures list
- Caution in use of "missing or not reportable" language

**Comments on Quality Measures Included**

First, we would like to restate our appreciation for the focus given to cardiovascular care in the list of QRS measures, as well as our appreciation of the attention made to making sure the information generated by the QRS is usable and understandable by consumers.

The AHA/ASA continues to support the direction that CMS has taken with the QRS measures list. We support its focus on the clinical management of cholesterol and the control of high blood pressure, prevention and screening, specifically tobacco use cessation and adult body mass index assessment, and measures related to customer service and access to needed care.

It continues to be difficult to comment in detail on all of the measures, however, because full measure specifications are not available for non-endorsed measures. It remains unclear to us why CMS continues to propose non-endorsed measures for conditions such as lipid control, given that endorsed measures already exist.

In our previous comments, we encouraged CMS to consider the use of different specific measures for its purposes related to BMI, breast cancer screening and pharmacotherapy for asthma for adults, specifically NQF 0421, NQF 0031, and NQF 0047, respectively. We believe that these measures serve the same purpose as those in the notice, but have also gone through the NQF endorsement process and support one of CMS' stated goals for the QRS program - to align with priority measures in currently implemented state, federal, and private sector programs.

**Additional Medication Adherence Measures for Inclusion**

In our previous comments we also suggested the addition of medication adherence measures, given their connection to the goals of the National Strategy for Quality Improvement in Health Care, alignment with which was stated as a goal by CMS in the introduction of the November notice. Integral to the achievement of the strategy's goals is medication adherence and we continue to recommend a stronger emphasis on the use of medication adherence performance measures in QRS to address the widely recognized and important problem of poor adherence to medications essential in the management of chronic illnesses, particularly diabetes, high blood pressure and high blood lipids.

We take this opportunity to reiterate the fact that there is significant potential for improving the quality of care through careful medication management. Including medication adherence would also be consistent with the recent findings of a National Quality Forum Task Force that ranked

medication management in the top 5 high-leverage opportunities for measurement. Chronic conditions account for the great majority of the health burden to patients and costs to our health care system, and for most of these conditions, medications are a first line of therapy. Poor adherence to medications is a widely recognized factor in failure of therapy, contributes substantially to increased costs, and has been recognized as America's "other drug problem." Yet, there are very few QRS measures related to medication use, and specifically for adherence to medications treating chronic conditions.

As we noted in our previous letter, we recommend the inclusion of three Pharmacy Quality Alliance (PQA) medication adherence measures in their current form in the proposed quality measure set. These measures include adherence to medications for three high-prevalence, chronic conditions - high blood pressure, diabetes, and high cholesterol.

**Addition of Cardiac Rehabilitation Referral Measure**

Each year, roughly 915,000 Americans will have a heart attack and more than 30% will have a second and potentially fatal event.[1] Cardiac rehabilitation (CR) reduces the risk of a future cardiac event by stabilizing, slowing, or even reversing the progression of CVD.[2] Patients with other cardiovascular diseases such as valve repair and heart failure also benefit from a CR program. Cardiac rehabilitation improves the health and recovery of those who suffer from CVD and specifically, the benefits of CR include a 20-30% reduction in all-cause mortality rates[3,4]; reduced symptoms (angina, dyspnea, fatigue)[5,6]; improved health factors like lipids and blood pressure[5]; enhanced ability to perform activities of daily living[5]; improved health-related quality of life[5]; improved psychosocial symptoms[7]; reduced hospitalizations and use of medical resources[5]; and increased ability to return to work or engage in leisure activities[8].

Despite its clear benefits, CR remains underutilized[9, 10] and among the main reasons for low participation in CR is the lack of a referral.[11] Medicare recently announced its reimbursement will now include all recommended conditions, including heart failure, although it is limited to certain patients with compromised ejection fraction (about half of the HF patient population)[12]. NQF has endorsed a measure for cardiac rehabilitation referral and we propose its inclusion in the QRS measure set.

NQF 0462, Cardiac Rehabilitation Patient Referral From an Inpatient Setting, tracks "all patients hospitalized with a primary diagnosis of an acute myocardial infarction (MI) or chronic stable angina (CSA), or who during hospitalization have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac

[1] Go AS, Mozaffarian D, et al.,; on behalf of the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart disease and stroke statistics—2014 update: a report from the American Heart Association. Circulation. 2014;129:e28–e292.

[2] Balady GJ., et al., Referral, enrollment, and delivery of cardiac rehabilitation/secondary prevention programs at clinical centers and beyond: a presidential advisory from the American Heart Association. *Circulation.* 2011; 124:2951-2960.

[3] Geol K., Lennon RJ, Tilbury RT et al, Impact of Cardiac Rehabilitation on Mortality Following PCI. *Circulation.* 2011;123:2344-2352.

[4] Taylor RS, Unal B, Critchley JA, Capewell S. Mortality reductions in patients receiving exercise-based cardiac rehabilitation: how much can be attributed to cardiovascular risk factor improvements? *Eur J Cardiovasc Prev Rehabil.* 2006;13(3):369-374.

[5] Jolliffe JA, et al., Exercise-based rehabilitation for coronary heart disease. *Cochrane Database Syst Rev.* 2001;(1):CD001800.

[6] Benz Scott L, Gravely S, Sexton TR, Brzostek S, Brown DL. Effect of Patient Navigation on Enrollment in Cardiac Rehabilitation. *JAMA Intern Med.* 2013;173(3):244-246. doi:10.1001/2013.jamainternmed.1042.

[7] Milani RV, Lavie CJ. Impact of cardiac rehabilitation on depression and its associated mortality. *Am J Med.* 2007;120(9):799-806

[8] Williams MA, Ades PA, Hamm LF, et al. Clinical evidence for a health benefit from cardiac rehabilitation: an update. *Am Heart J.* 2006;152(5):835-841.

[9] Suaya JA, et al, Use of cardiac rehabilitation by Medicare beneficiaries after myocardial infarction or coronary bypass surgery. *Circulation*. 2007;116:1653–1662.

[10] Centers for Disease Control and Prevention (CDC). Receipt of outpatient cardiac rehabilitation among heart attack survivors—United States, 2003. *MMWR Morb Mortal Wkly Rep*. 2008;57:89 –94.

[11] [11] Sanderson BK, et al., Factors associated with the failure of patients to complete cardiac rehabilitation for medical and nonmedical reasons. *J Cardiopulm Rehabil.* 2003;23:281–289.

[12] Centers for Medicaid and Medicaid Services. Decision Memo for Cardiac Rehabilitation (CR) Programs - Chronic Heart Failure (CAG-00437N) February 18, 2014.

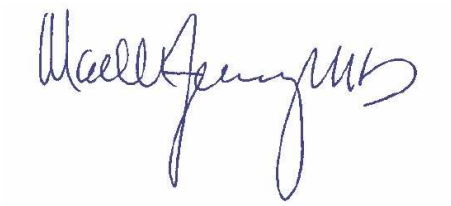
transplantation are to be referred to an early outpatient cardiac rehabilitation/secondary prevention (CR) program." We believe that including this measure as part of the QRS program offers a unique opportunity to incent cardiac rehabilitation and allow patients to see how plans perform on this import element of care delivery as part of the cardiovascular care composite. Additionally, we believe it also reveals the attention given by a qualified health plan (QHP) to care coordination and supports the separate care coordination domain.

**Display of "Missing" or "Not Reportable" Data**

In the proposed scoring specifications, CMS indicates that it will "conduct research and consumer testing to determine the manner to display and convey information about missing and non-reportable data in the QRS" and we look forward to hearing what CMS learns. However, we urge caution in using the term "missing." At the QHP level, we are concerned that it may be interpreted by consumers and other stakeholders as meaning that the plan did not collect the data or did not meet the scoring standards, and in turn, be perceived of lesser quality or value when the real issue is that the population or number of events was too small to calculate a valid measure. Newer plans, like cooperatives, or smaller plans are more likely to have "missing" measures and may be disadvantaged by this term. Therefore, we urge CMS to make sure that the language it ultimately selects makes it clear that the data is not available for an appropriate reason.

Thank you again for the opportunity to provide input on this exciting program. Our staff remains ready to answer any questions or provide additional information CMS may need. To this end, please feel free to contact Madeleine Konig, Senior Policy Analyst, at madeleine.konig@heart.org or 202.785.7930.

Sincerely,



Mariell Jessup, MD, FAHA
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