Update on the Measures Application Partnership (MAP)

March 23, 2016

NATIONAL QUALITY FORUM

Pre-Rulemaking Overview

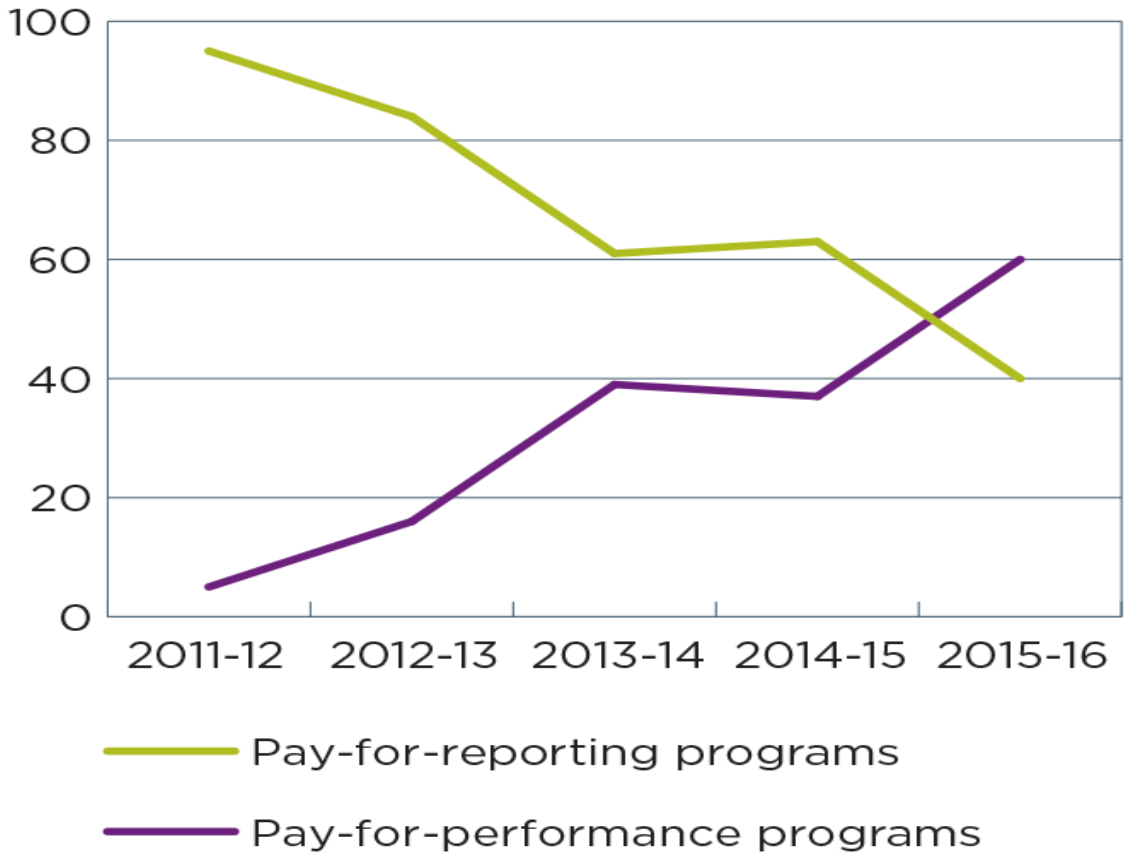
- The Affordable Care Act (ACA)requires HHS to undergo an annual pre-rulemaking process to provide input and gain consensus on measures being considered for public reporting and performance-based payment programs
- Pre-Rulemaking Process:
  - HHS makes available a list of measures it is considering adopting for use in Medicare programs by December 1
  - MAP provides input on these measures by February 1
  - HHS considers this input when selecting measures and executing the rulemaking process

Pre-Rulemaking Findings

MAP reviewed 141 measures for 16 federal programs

- Key changes in the measures under consideration:
  - More outcome measures were submitted for consideration than process measures this year
  - An increasing number of measures under consideration are still under development
    - » More than 60% of submitted measures not fully tested
    - » Less than 30% of submitted measures were NQF-endorsed
- Key changes to the CMS programs:
  - HHS goal of tying 90% of all traditional Medicare payments to quality or value by 2018
  - Passage of the IMPACT Act and MACRA has expanded value-based purchasing to post-acute and clinician programs

Increase in Measures under Consideration for Pay for Performance



2015-2016 Pre-Rulemaking Input

Attribution/Shared Accountability

- The shift from process to outcome measures makes it challenging to appropriately assign patients and their outcomes when multiple organizations and providers play a role
- Measures and programs need to recognize multiple entities are involved in delivering care and there is both individual and joint responsibility to improve quality and cost
- Notable examples:
  - 30-day readmission measures, mortality measures, or episode-based payment measures places significant responsibility for a patient's unplanned post-discharge care on acute care hospitals
  - Increasing emphasis on team-based care makes in challenging to hold an individual clinician responsible for a patient's outcome
  - Use of setting-specific programs to balance population health goals

2015-2016 Pre-Rulemaking Input

Disparities and Sociodemographic Status (SDS) Adjustment

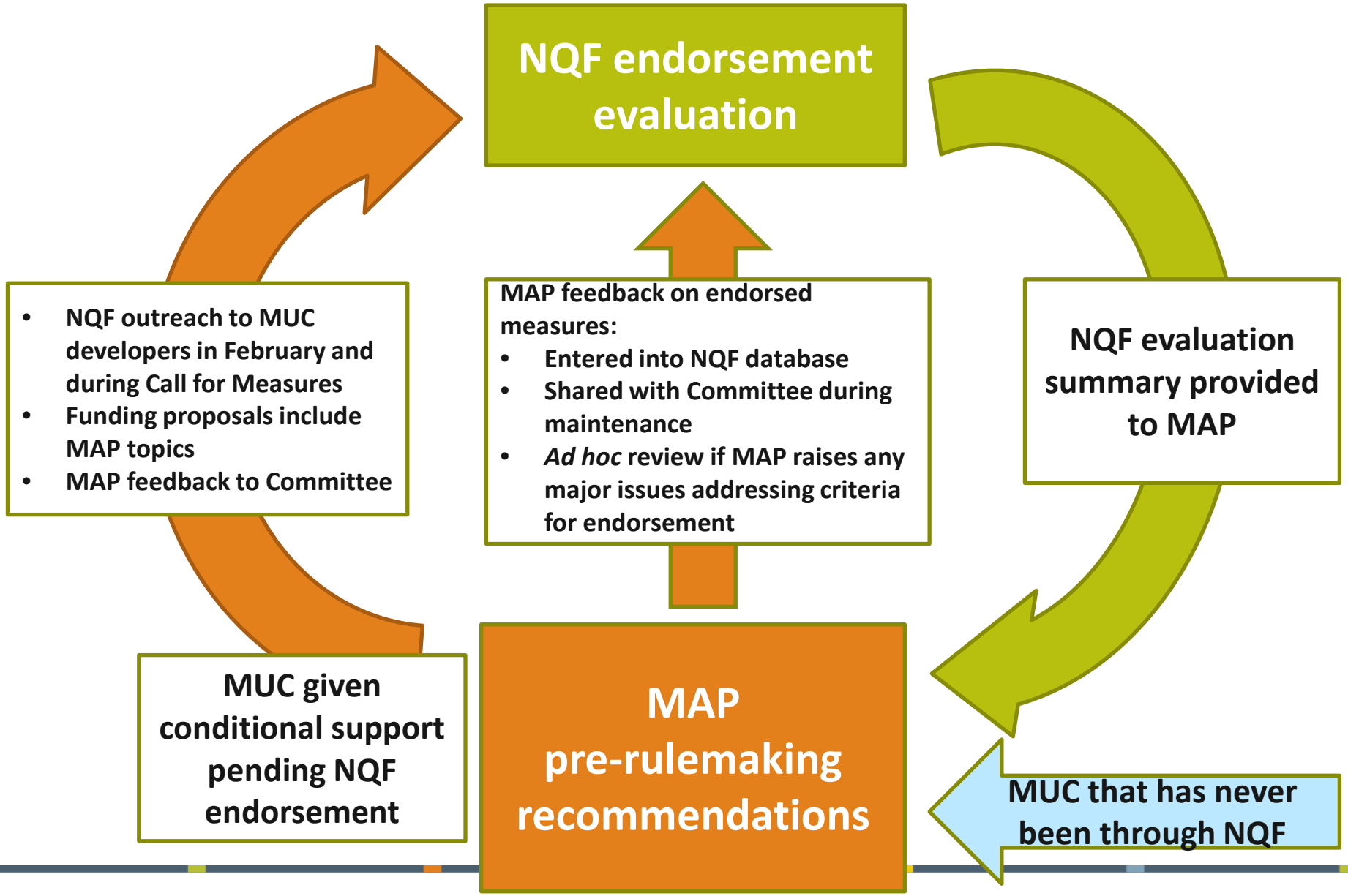
- MAP continues to support the two-year SDS trial period undertaken by NQF
- MAP continues to recommend that individual measures that are proposed for selection in programs be reviewed by the relevant standing committees to determine if SDS adjustment is appropriate
- MAP reinforces the principle that the decision to include SDS factors in an outcome measure's risk adjustment model should be made on a measure-by-measure basis, and should be supported by strong conceptual and empirical evidence
- MAP looks to the work of the Disparities Standing Committee (DSC) to ensure that MAP's recommendations will help to reduce healthcare disparities

2015-2016 Pre-Rulemaking Input

Better Integration with the CDP Process:

- Interdependencies between the processes require a seamless flow of information:
  - MAP depends on measure endorsement to ensure sound testing and robust evidence
  - As MAP considers measures earlier in their lifecycle its recommendations should be shared with CSAC and the Standing Committees

CDP-MAP INTEGRATION – INFORMATION FLOW



2015-2016 Pre-Rulemaking Input

Implementation of Intended Use:

- MAP discussed the need to implement the additional designation recommended by the Intended Use Expert Panel in its work
- MAP noted the recommendation to examine the interaction of key measure and program attributes to inform recommendations

Questions?

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CSAC DISCUSSION

Recommendations:

- What information from does CSAC feel is most important for the Standing Committees to receive?
- What information from the endorsement process is most important for MAP to receive?
- How should MAP consider implementing the recommendations of the Intended Use Expert Panel?

Attribution: Principles and Approaches

March 23, 2016

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March 21, 2016

Policy Context: From Volume to Value

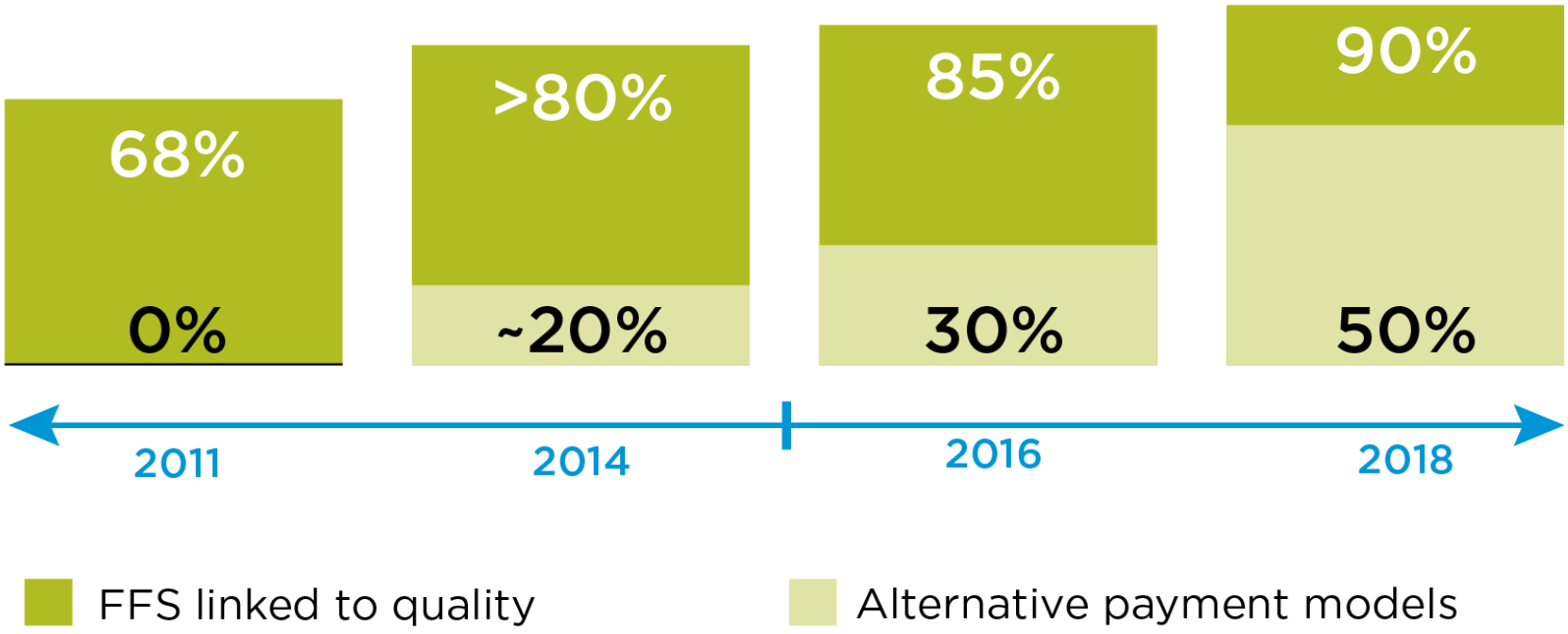
- Shift to performance-based payment system
  - ACA (Hospital VBP, HRRP, MSSP)
  - IMPACT (PAC/LTC settings)
  - MACRA (MIPS)
- Care increasingly delivered through shared accountability models
  - HHS goal to tie 30% of Medicare payments to APMs
  - Implementation of the Accountable Health Communities Model

HHS Payment Model Taxonomy

	Category 1 FFS; no link of payment to quality	Category 2 FFS ; link of payment to quality	Category 3 APMs built on FFS architecture	Category 4 Population-based payment
Description	Payment based on volume of services; no link to quality or efficiency	Payment varies based on quality or efficiency	Some payment linked to population or episode management. Payment triggered by delivery of service but opportunities for shared savings or risk	Volume not linked to payment. Providers are responsible for care of a beneficiary over time
Medicare Examples	Limited in Medicare FFS	HVBP PVBM HRRP HACRP	ACOs Medical homes Comprehensive Primary Care Initiative Comprehensive ERSD Model BCPI	Eligible Pioneer ACOs in years 3-5

Policy Context: From Volume to Value

All Medicare Fee-For-Service (FFS) payments



Current Challenges to Attribution

- Lack of clarity in attribution approaches limits the use of meaningful cost and outcome measures
- How to align the attribution approach to the accountable entity's locus of control
- How to align care delivery model or payment with the attribution approach
- Impact of small numbers of patients in provider profiles on reliability
- Intensifying debates on physician payment

Project Purpose and Objectives

- **Purpose**: To provide greater guidance to the field on approaches to the attribution issue
- Through commissioned authors and multistakeholder Committee:
  - Explore current approaches to attribution
  - Analyze their strengths and weaknesses
  - Describe subset of measures affected by attribution
  - Develop models to enable testing on CMS data
  - Identify guiding principles and recommendations on selecting and implementing attribution models

Potential Impact of this Work

- Landscape analysis
  - Summary of current and theoretical approaches to attribution
  - Outline strengths and weaknesses of each approach
- Develop principles for selection of an attribution approach
- Impact on the endorsement and selection process
- Guidance to HHS on future policy

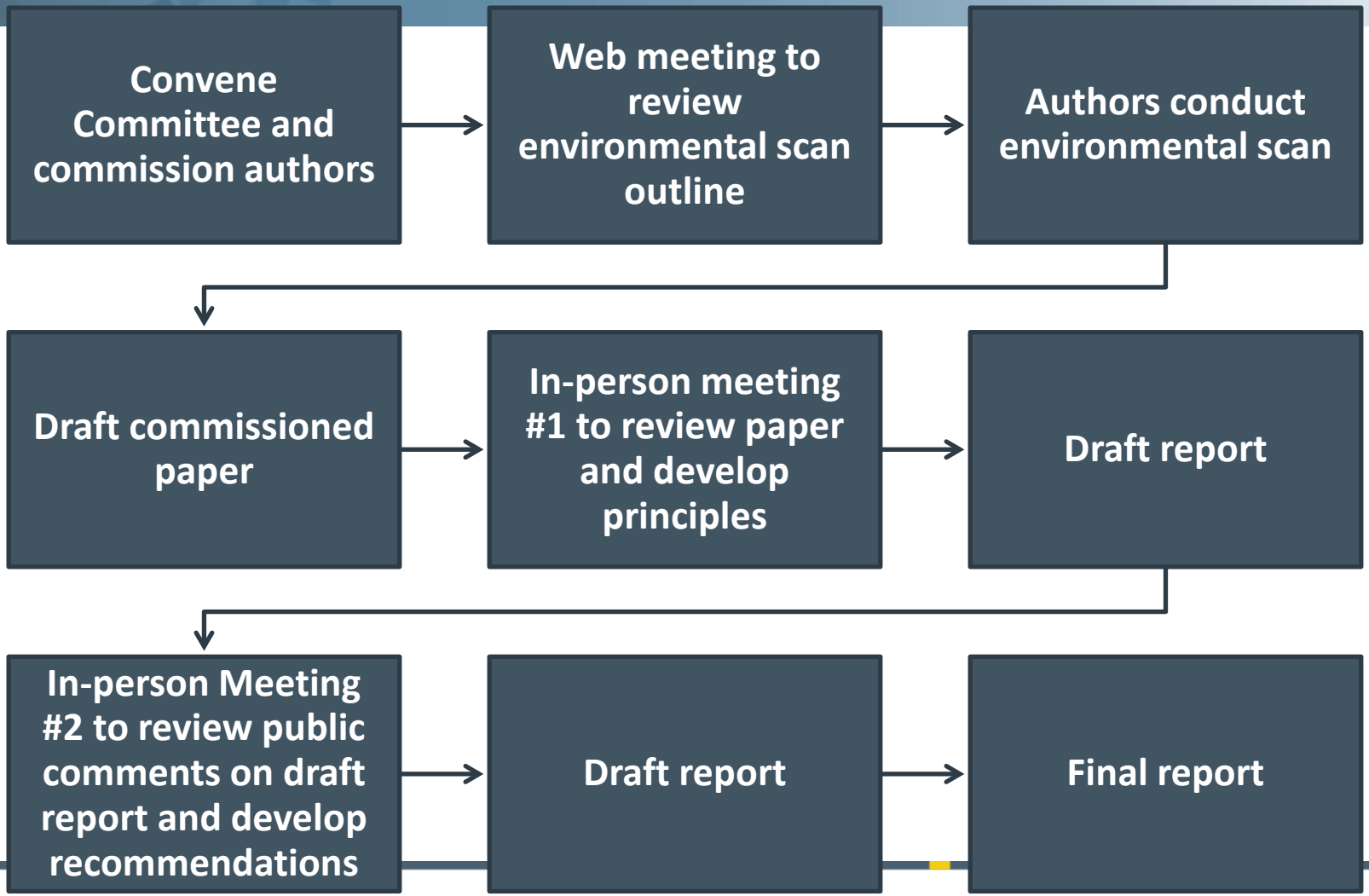
Committee Members

- **Ateev Mehrotra, MD, MPH (co-chair)**
- **Carol Raphael (co-chair)**
- Michael Barr, MD, MBA, MACP
- Jenny Beam, MS
- Jill Berger, MAS
- Anne Deutsch, PhD, RN, CRRN
- Elizabeth Drye, MD, SM
- Troy Fiesinger, MD
- Charles Hawley, MA
- Ari Houser
- Keith Kocher, MD, MPH, MPhil
- Robert Kropp, MD, MBA, MACP
- Danielle Lloyd, MPH
- Edison Machado, MD, MBA
- Ira Moscovice, PhD
- Jennifer Nowak, RN, MSN
- Jennifer Perloff, PhD
- Brandon Pope, PhD
- Laurel Radwin, PhD, RN
- Jack Resneck, MD
- Michael Samuhel, PhD
- Robert Schmitt, FACHE, FHFMA, MBA, CPA
- Nathan Spell, MD
- Srinivas Sridhara, PhD, MS
- Bharat Sutariya, MD, FACEP
- L. Daniel Muldoon **(federal liaison)**

Commissioned Authors

- Andrew Ryan, PhD, University of Michigan
- Ariel Linden, DrPH, University of Michigan
- Brahmajee Nallamothu, MD , University of Michigan
- Rachel Werner, MD, PhD, University of Pennsylvania
- Kristin Maurer, MPH(c), University of Michigan

Project Activities and Timeline



Key Meeting Dates

Meeting	Date/Time
Web Meeting #2	March 29, 2016, 12-2pm ET
In-Person Meeting #1	June 14, 2016, 8:30am-5pm ET June 15, 2016, 8:30am-5pm ET
Web Meeting #3	June 21, 2016, 1-3pm ET
In-Person Meeting #2	August 30, 2016, 8:30am-5pm ET August 31, 2016, 8:30am-5pm ET
Web Meeting #4	September 9, 2016, 2-4pm ET
Web Meeting #5	November 15, 2016, 12-2pm ET

Questions?

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CSAC DISCUSSION

Recommendations:

- What guidance does the CSAC have for the Attribution Committee and commissioned authors?
- Are there certain care delivery or payment models where attribution is a particular concern?
- Are there additional challenges to attribution we should note as we start this work?
- How can NQF build on this work to ensure measurement accurately reflects who is responsible for outcomes?

Update on the Disparities Standing Committee and SDS Trial Period

March 23, 2016

NATIONAL QUALITY FORUM

March 21, 2016

Disparities Committee Charge

1. Develop a roadmap for how measurement and associated policy levers can be used to proactively eliminate disparities

2. Review implementation of the revised NQF policy regarding risk adjustment for SDS factors and provide input on the evaluation of the SDS trial period.

3. Provide a cross-cutting emphasis on healthcare disparities across all of NQF's work.

NQF Policy Change: Trial Period

- The NQF Board approved a **two-year trial period** prior to a permanent change in NQF policy.
- Under the new policy, adjustment of measures for SDS factors is no longer prohibited.
- During the trial period, if SDS adjustment is determined to be appropriate for a given measure, NQF will endorse one measure with specifications to compute:
  - SDS-adjusted measure
  - Non-SDS version of the measure (clinically adjusted only) to allow for stratification of the measure

NQF Policy Change: Trial Period (cont.)

- Each measure must be assessed individually to determine if SDS adjustment is appropriate.
- Not all measures should be adjusted for SDS factors (e.g., central line infection would not be adjusted)
  - Need conceptual basis (logical rationale, theory) and empirical evidence
- The recommendations apply to any level of analysis including health plans, facilities, and individual clinicians.

Measures Included in the Trial Period

- **ALL measures submitted to NQF after April 15, 2015 will be considered part of the trial period**, and Standing Committees may consider whether such measures are appropriately adjusted for SDS factors as part of their evaluation.
  - Newly-submitted measures
  - Previously-endorsed measures undergoing maintenance
  - Measures with conditional endorsement (e.g., Admissions/Readmissions, Cost & Resource Use)
  - Measures undergoing ad hoc review

NQF Standing Committee Consideration of SDS Adjustment

- Questions for Standing Committees to consider when reviewing SDS-adjusted measures:
  - Is there a conceptual relationship between the SDS factor and the measure focus?
  - Is the SDS factor present at the start of care?
  - Is there variation in prevalence of the SDS factor across measured entities?
  - Does empirical analysis (as provided by the measure developer) show that the SDS factor has a significant and unique effect on the outcome in question?
  - Is information on the SDS factor available and generally accessible for the measured patient population?

Projects Contributing to Trial Period to Date

- Cost and Resource Use (2014)
- Admissions/Readmissions (2014)
- Cardiovascular, Phase 3
- Pediatrics

Cost and Resource Use

- Three measures were endorsed with the condition that they enter the trial period:
  - #2431: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for **Acute Myocardial Infarction** (AMI) (CMS/Yale)
  - #2436: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for **Heart Failure** (HF) (CMS/Yale)
  - #2579: Hospital-level, risk-standardized payment associated with a 30-day episode of care for **pneumonia** (CMS/Yale)

Cost and Resource Use

- Variables initially considered (based on initial conceptual analysis and data availability)
  - Educational attainment or income (from census data using patient zip code)
  - Medicaid status (proxy for low income and insurance coverage)
  - Black or white race
- SC asked developer to broaden the conceptual model and add to the some literature review
- Empirical analysis explored race (Black/non-Black) and Medicaid enrollment/Dual Status (as a proxy for low income)

Cost and Resource Use

- Based on the empirical analysis, the developers chose **NOT** to include the SDS variables in the model, citing the nominal impact of the SDS variables on the risk model performance and payment outcomes
- Ultimately the Committee voted to continue endorsement of the measures without inclusion of SDS factors in the risk-adjustment approach
- This decision was approved by CSAC and ratified by the Board

Admissions/Readmissions

- 17 admission and readmission measures endorsed with the condition they be reviewed for the need for SDS adjustment
- The Standing Committee determined that 16 measures should enter the trial period
- The Standing Committee met in September to review the SDS factors/variables that developers plan to test

Admissions/Readmissions: Input from SC on Empirical Approach

- Tension: "robustness" of proposed factors vs. data availability and accessibility
- More than one appropriate way to accomplish risk adjustment: NQF should not be prescriptive regarding methods or SDS factors
  - Potential for inclusion: patient characteristics that are present prior to treatment and are known or suspected confounder

Admissions/Readmissions: Input from SC on Empirical Approach

- Encouraged consideration of age, gender, measure of poverty (e.g., dual eligibility status)
- Test community-level variables when patient-level data are not available or not sufficiently robust
  - Justify any decision not to include such factors
- Geographic proxy data should represent the actual SDS characteristics of the patient as accurately as possible
  - Data derived from 9-digit ZIP Code may be best
  - Data derived from 5-digit ZIP Code or county too heterogeneous
- Urged caution on the use of race as a proxy for patient SDS, as it is often difficult to assess the underlying concept that race is measuring

Admissions/Readmissions: Empirical Analysis Review

- The Standing Committee met in March to review the empirical analysis for 6 of the measures
- All were submitted without SDS variables in the final risk adjustment models
  - Variables examined included race/ethnicity, payor, AHRQ composite index, zip code median income, zip code distribution of education
- The Standing Committee is currently voting on their recommendations
- The Committee will meet again in May to review the remaining measures

Cardiovascular, Phase 3

- 27 measures evaluated; 10 included risk-adjustment
- 4 of these included information on the conceptual rationale for inclusion of SDS factors
  - Variables examined included race, dual-eligibility status, and AHRQ composite index
  - These ultimately **not included** in risk-adjustment
- 6 did not include information on the conceptual rationale in the written submission, but the topic was addressed briefly during discussion of the measures

Pediatrics

- 24 measures evaluated; 11 included risk-adjustment
- Measures based on 2 instruments (PRO-PMs)
- Relatively little discussion of risk-adjustment approach
  - 1 included conceptual rationale
    - » Variables considered included age, self-reported health status, gender, education, health condition type (Complex Chronic vs. Non-Complex Chronic)
    - » Only age and self-reported health status included in final risk-adjustment
  - Remainder did not have conceptual rationale
    - » Variables considered included child gender, age, and race/ethnicity; caregiver age, race/ethnicity, English proficiency, and educational attainment
    - » Only respondent education included in final risk-adjustment

Challenges: Input from NQF's Stakeholders

- Limited availability of patient-level data
  - 9-digit ZIP Code/census block data not easily accessible
- Risk models using currently available SDS adjustors are not demonstrating an association for measures with a clear conceptual basis for SDS adjustment
- Concerns about factors selected/analyzed to date
  - Available proxies may not be adequate
  - Inclusion of race questioned
- Call for a more prescriptive approach
  - Empirical methods
  - Variables tested

Recommendations:

- Does the CSAC have recommendations about the use of variables that are currently available?
- How can NQF help to encourage the development of innovative approaches to SDS adjustment?

NQF Measure Incubator

NATIONAL QUALITY FORUM

THE CHALLENGE:
MORE MEASURES THAT MATTER

Despite the widespread use of many good quality healthcare measures in the past two decades, there are areas of health and healthcare that still do not have enough or the right kinds of measures to drive improvement. Measure development hasn't kept pace for care of people with Alzheimer's disease, multiple chronic conditions, or those receiving palliative or end-of-life care. These and other "gap" areas, such as behavioral health, diagnostic accuracy, and measures that use patient-reported outcomes, need better data to benchmark performance and help ensure that patients receive high-quality care.

The NQF Measure Incubator is an innovative effort that facilitates efficient measure development and testing through collaboration and partnership. It addresses important aspects of care for which quality measures are underdeveloped or non-existent. In leading the Measure Incubator, NQF's role is to facilitate the work of others. NQF itself will not develop measures.

Measure gaps occur for many reasons. A principal cause is the measure development process itself. The designing, testing, and disseminating quality measures can be burdensome, costly, and time-consuming. It can take two to three years to develop a new measure and put it into use.

Similar to incubators that nurture entrepreneurs in technology environments, the NQF Measure Incubator is designed to nurture development of needed measures. The Incubator connects groups interested in particular measure concepts with measure development experts, financial and technical resources, and data.

What sets this approach apart and makes it innovative is having continuous access to data to more rapidly test and adjust measures to reduce measure development time. The Measure Incubator also holds promise to make measure development more efficient by standardizing relevant best practices.

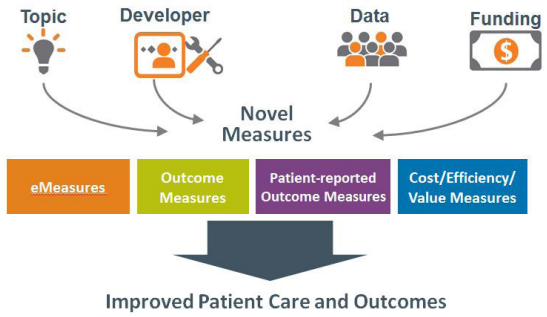
THE CONCEPT:
AN NQF MEASURE INCUBATOR

The Measure Incubator embodies NQF's mission by providing the quality measurement community with a more efficient environment to develop and test measures that matter.

The goals of the NQF's Measure Incubator are to:

- Facilitate development of more meaningful measures that are difficult to construct and test;
- Rapidly fill measurement gap areas
- Spur development of electronic clinical quality measures (eCQMs) to take advantage of the data collected through EHRs and to help enable measurement—and improvement—in real time
- Drive outcome-based healthcare measurement that better reflects the voice of patient and caregiver
- Advance measurement science by making tools and test beds more accessible to address tough challenges in measurement
- Improve availability of meaningful measures by prospecting for proven measures in use by leading providers that could be developed into national standards

NQF Measure Incubator:
Getting to quality measures that matter



PROVING THE CONCEPT:
TESTING THE MEASURE INCUBATOR

NQF currently is working with an array of stakeholders, data partners, and measurement development experts to test the effectiveness of the Measure Incubator in the following ways:

- "**Proof of concept**" with OptumLabs, where access to its collaborative environment and unique data resources will provide participating OptumLabs partner organizations the opportunity to incubate and test measures. Several measure projects are already underway in this testing stage, including:

  - » **University of Maryland**—refining a series of process measures as part of a larger research study on dementia and Alzheimer's disease;
  - » **AARP**—a founding contributor to the Incubator, AARP is exploring the creation of measures addressing dementia/Alzheimer's disease and homebound populations;
  - » **Mayo Clinic**—developing "phenotypes" of patients with multiple chronic conditions, as a precursor to measure development for this complex population.
- **PatientsLikeMe**, with funding from the Robert Wood Johnson Foundation, will test NQF's 2013 pathway to take patient-reported outcomes and translate them into patient-reported outcome (PRO) measures. This work aims to develop measures that capture what's important to patients—from their day-to-day experiences like living with pain to how they are functioning after surgery, and more. With these metrics, the goal is to help patients and their physicians make better healthcare decisions and spark improvements.
- **Minnesota Community Measurement**, a pioneer in patient reported outcome (PRO) performance measure development, is working through the NQF Measure Incubator to develop and test a performance measure using an appropriate COPD PRO as a measure of physician practice outcomes. GSK, a global leader in respiratory disease, will also collaborate with the Incubator as the sponsor of the project.
- A design session held February 24-25, 2016, convened more than 60 stakeholders representing all sectors interested in measure development to refine the Incubator process.

Final evaluation and modification of the Incubator process will reflect what was learned from the proof of concept work and the design session to ensure that measure development via the Incubator is agile, iterative, replicable, and efficient.

NQF'S LEADERSHIP OF THE MEASURE INCUBATOR

As a national, trusted convener of quality measurement stakeholders, NQF has the experience and contacts in the quality community to bring together the requisite expertise, knowledge, and resources to develop, launch and manage the Measure Incubator.

In leading the Measure Incubator, NQF is uniquely positioned to:

- Effectively match measure developer(s) with projects, using NQF's strong relationships with measure developers and other technical experts;
- Share its insights into measure gaps and "measures that matter," based on NQF's substantial work to vet measures and to advance the science of quality measurement;
- Provide a pathway to take patient reported outcome to performance measures, based on its seminal work in this area in 2013
- Understand and contract with the right data providers to ensure that appropriate data are being used each project and for the measures undergoing testing;
- Leverage its experience working to expand and refine electronic quality measures;
- Convene leading experts in the field who bring the most current evidence-based data and knowledge to Measure Incubator projects.

MEASURE INCUBATOR GOVERNANCE: INCUBATOR ADVISORY COUNCIL

The Incubator Advisory Council (IAC), an advisory panel to the NQF Board, develops clear and transparent conflict of interest policies that reflect NQF's values and protect NQF's mission. The IAC also advises NQF on Incubator funding and project selection, and makes recommendations to ensure that NQF's measure endorsement work is kept separate from the Incubator environment. For example, incubated measures will be conferred no advantage in the endorsement process.

Members of the Incubator Advisory Council include:

- **Carolyn Clancy, M.D.**, chief medical officer, Veterans Health Administration
- **Robert Galvin, M.D., MBA**, operating partner, Equity Healthcare, The Blackstone Group
- **Michael McGinnis, M.D.**, National Academy of Medicine senior scholar and executive director, Institute of Medicine Roundtable on Value & Science-Driven Health Care.
- **Eric Schneider, M.D., M.Sc.**, senior vice president for policy and research, The Commonwealth Fund
- **Susan Sheridan, MIM, MBA, DHL**, director of patient engagement, Patient-Centered Outcomes Research Institute (PCORI)
- **Jed Weissberg, M.D.**, senior fellow, Institute for Clinical and Economic Review (ICER)

Measure Incubator contact: Jason Goldwater, jgoldwater@qualityforum.org