NATIONAL QUALITY FORUM

Measure Applications Partnership

Coordinating Committee In-Person Meeting

January 24-25, 2016

NATIONAL QUALITY FORUM

Measure Applications Partnership Coordinating Committee Meeting

Day 2

January 25, 2017

Day 2 Agenda

- Day 1 recap
- Discuss pre-rulemaking cross-cutting issues:
  - *Attribution*
  - *Risk adjustment for sociodemographic factors*
- Review refinements to the Medicaid Taskforce processes
- Discuss potential improvements to the pre-rulemaking process

Day 1 Recap

Pre-Rulemaking Cross-Cutting Issues: Attribution

Current Landscape

- Recent legislation such as IMPACT and MACRA demonstrate the continued focus on value-based purchasing to drive improvements in quality and cost by re-aligning incentives.
- Implementing pay for performance models requires knowing who can be held responsible for the results of the quality and efficiency measures used to judge performance.
  - *Increasingly challenging as quality is assessed on outcome measures rather than process or structural measures.*
- Attribution can be defined as the methodology used to assign patients, and their quality outcomes, to providers or clinicians.
  - *Attribution models help to identify a patient relationship that can be used to establish accountability for quality and cost.*
- Moving the system away from fee-for-service payment to alternative payment models has highlighted the need to better understand how patient outcomes and costs can be accurately attributed in a system increasingly built on shared accountability.

Attribution Project Purpose

- Taking in account trends toward providing care in shared accountability structures, provide multistakeholder guidance on the field on approaches to issues of attribution:
  - Identify key challenges in attribution
  - Develop a set of guiding principles
  - Identify elements of an attribution model
    - Explore strengths and weaknesses
  - Identify recommendations for developing, selecting, and implementing an attribution model

Attribution 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)**

Environmental Scan Highlights

- Models categorized by:
  - Program stage
  - Type of provider attributed
  - Timing
  - Clinical circumstances
  - Payer/programmatic circumstances
  - Exclusivity of attribution
  - Measure used to make attribution
  - Minimum requirement to make attribution
  - Period of time for which provider is responsible
- 163 models in use or proposed for use
  - 17% currently in use
  - 89% use retrospective attribution
  - 77% attribute to a single provider, mainly a physician

Commissioned Paper Findings

- Best practices have not yet been determined
  - *Existing models are largely built off of previously used approaches*
  - *Trade-offs in the development of attribution models should be explored and transparent*
- No standard definition for an attribution model
- Lack of standardization across models limits ability to evaluate

Challenges

- Greater standardization among attribution models is needed to allow:
  - *Comparisons between models;*
  - *Best practices to emerge.*
- Little consistency across models but there is evidence that changing the attribution rules can alter results.
- Lack of transparency on how results are attributed and no way to appeal the results of an attribution model that may wrongly assign responsibility.

Addressing the Challenges

- To address these challenges the Committee:
  - *Developed guiding principles*
  - *Made recommendations*
  - *Created the Attribution Model Selection Guide*

- These products allow for greater standardizations, transparency, and stakeholder buy-in:
  - *Allow for evaluation of models in the future*
  - *Lay the groundwork to develop a more robust evidence base*

Guiding Principles Preamble

- Acknowledge the complex, multidimensional challenges to implementing attribution models as the models can change depending on their purpose and the data available.
- Grounded in the National Quality Strategy (NQS) as attribution can play a critical role in advancing these goals.
- Recognize attribution can refer to both the attribution of patients for accountability purposes as well as the attribution of results of a performance measure.
- Highlighted the absence of a gold standard for designing or selecting an attribution model; must understand the goals of each use case.
- Key criteria for selecting an attribution model are: actionability, accuracy, fairness, and transparency.

Guiding Principles

1. Attribution models should fairly and accurately assign accountability.
2. Attribution models are an essential part of measure development, implementation, and policy and program design.
3. Considered choices among available data are fundamental in the design of an attribution model.
4. Attribution models should be regularly reviewed and updated.
5. Attribution models should be transparent and consistently applied.
6. Attribution models should align with the stated goals and purpose of the program.

Attribution Model Selection Guide

- **Current state:**
  - *Tension between the desire for clarity about an attribution model's fit for purpose and the state of the science related to attribution*
  - *Desire for rules to clarify which attribution model should be used in a given circumstance, but not enough evidence to support the development of such rules at this time.*
- **Goals of the Attribution Model Selection Guide:**
  - Aid measure developers, measure evaluation committees, and program implementers on the necessary elements of an attribution that should be specified.
  - Represent the minimum elements that should be shared with the accountable entities

The Attribution Model Selection Guide

What is the context and goal of the accountability program?	• What are the desired outcomes and results of the program? • Is the attribution model evidence-based? • Is the attribution model aspirational? • What is the accountability mechanism of the program? • Which entities will participate and act under the accountability program?
How do the measures relate to the context in which they are being used?	• What are the patient inclusion/exclusion criteria? • Does the model attribute enough individuals to draw fair conclusions?
Which units will be affected by the attribution model?	• Which units are eligible for the attribution model? • To what degree can the accountable unit influence the outcomes? • Do the units have sufficient sample size to meaningfully aggregate measure results? • Are there multiples units to which this attribution model will be applied?
How is the attribution performed?	• What data are used? Do all parties have access to the data? • What are the qualifying events for attribution, and do those qualifying events accurately assign care to the right accountable unit? • What are the details of the algorithm used to assign responsibility? • Have multiple methodologies been considered for reliability? • What is the timing of the attribution computation?

Recommendations for Attribution Models

- Build on the principles and Attribution Model Selection Guide.
- Intended to apply broadly to developing, selecting, and implementing attribution models in the context of public and private sector accountability programs.
- Recognized the current state of the science, considered what is achievable now, and what is the ideal future state for attribution models.
- Stressed the importance of aspirational and actionable recommendations in order to drive the field forward.

Use the Attribution Model Selection Guide to evaluate the factors to consider in the choice of an attribution model

- No gold standard; different approaches may be more appropriate than others in a given situation.
- Model choice should be dictated by the context in which it will be used and supported by evidence.
- Measure developers and program implementers should be transparent about the potential trade-offs between the accountability mechanism, the gap for improvement, the sphere of influence of the accountable entity over the outcome, and the scientific properties of the measure considered for use.

Attribution models should be tested

- Attribution models of quality initiative programs must be subject to some degree of testing for goodness of fit, scientific rigor, and unintended consequences.
  - *Degree of testing may vary based on the stakes of the accountability program, attribution models would be improved by rigorous scientific testing and making the results of such testing public.*
- When used in mandatory accountability programs, attribution models should be subject to testing that demonstrates adequate sample sizes, appropriate outlier exclusion and/or risk adjustment to fairly compare the performance of attributed entities, and sufficiently accurate data sources to support the model in fairly attributing patients/cases to entities.

Attribution models should be subject to multistakeholder review

- Given the current lack of evidence on the gold standard for attribution models, perspectives on which approach is best could vary based on the interests of the stakeholders involved.
- Attribution model selection and implementation in public and private sectors, such as organizations implementing payment programs or health plans implementing incentive programs should use multistakeholder review to determine the best attribution model to use for their purposes.

Attribution models should attribute care to entities who can influence care and outcomes

- Attribution models can unfairly assign results to entities who have little control or influence over patient outcomes.
- For an attribution model to be fair and meaningful, an accountable entity must be able to influence the outcomes for which it is being held accountable either directly or through collaboration with others.
- As care is increasingly delivered by teams and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control.

Attribution models used in mandatory public reporting or payment programs should meet minimum criteria

- In order to be applied to mandatory reporting or payment program attribution models should:
  - *Use transparent, clearly articulated, reproducible methods of attribution;*
  - *Identify accountable entities that are able to meaningfully influence measured outcomes;*
  - *Utilize adequate sample sizes, outlier exclusion, and/or risk adjustment to fairly compare the performance of attributed entities;*
  - *Undergo sufficient testing with scientific rigor at the level of accountability being measured;*
  - *Demonstrate accurate enough data sources to support the model in fairly attributing patients/cases to entities;*
  - *Be implemented with adjudication processes, open to the public, that allow for timely and meaningful appeals by measured entities.*

Coordinating Committee Discussion

- What are the implications of the Attribution Committee's findings for the work of MAP?
- How should MAP Workgroups consider attribution issues in their recommendations?
- How should MAP consider measures being used at different levels of analysis than endorsed?
- How can MAP balance attribution concerns with fostering shared accountability?

Refinements to the Medicaid Task Force Processes

Medicaid Project Background

- Core Set Creation and Updates
- Core Set Purpose
- MAP Medicaid Task Force Charge

The Affordable Care Act (ACA) and Adult Core Set

- ACA called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid.
- HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.
- HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee to the Agency for Healthcare Research and Quality's (AHRQ) National Advisory Council. It has been updated annually since that time, with recent iterations reflecting input from MAP.

CMS. Adult health care quality measures website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html. Last accessed May 2016.

CMCS Informational Bulletin "2017 Updates to the Child and Adult Core Health Care Quality Measurement Sets." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf Last accessed December 2016.

The Affordable Care Act (ACA) and Adult Core Set

- The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP.
- CMS and the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009.
- The measures contained within the core set are relevant to children ages 0-18 as well as pregnant women.

Centers for Medicare & Medicaid Services (CMS). CHIPRA Initial Core Set of Children's Health Care Quality Measures. Available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html. Last accessed January 2017.

CMCS Informational Bulletin "2017 Updates to the Child and Adult Core Health Care Quality Measurement Sets." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf Last accessed December 2016.

Medicaid Core Set Updates

- Core Sets must be updated annually
- MAP recommends updates to HHS/CMS
- Center for Medicaid and CHIP Services (CMCS) reviews MAP feedback with various internal/external stakeholders:
  - *Internal discussions with CMCS components*
  - *Broader discussions with CMCS Quality TAG, other stakeholders, CMS's Quality Improvement Council*
- CMS releases annual updates to both Core Sets in December of the following year

Medicaid Core Set Charge

- Consider states' experiences implementing the Core Sets
- Develop concrete recommendations for strengthening the Core Sets through identification of:
  - *Most important measure gaps and potential measures to address them*
  - *Measures found to be ineffective, for potential removal*
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals

MAP Task Forces

- The Medicaid Core Set work is facilitated by the Medicaid Adult and Child Task Forces.
- Task forces are time-limited and membership is drawn from current MAP Workgroups and Coordinating Committee based on relevant experience.
- Prior task forces include the Health Insurance Exchange Task Force, the Measure Selection Criteria and Impact Task Force, and the Strategy Task Force.

How CMS Uses Core Set Data

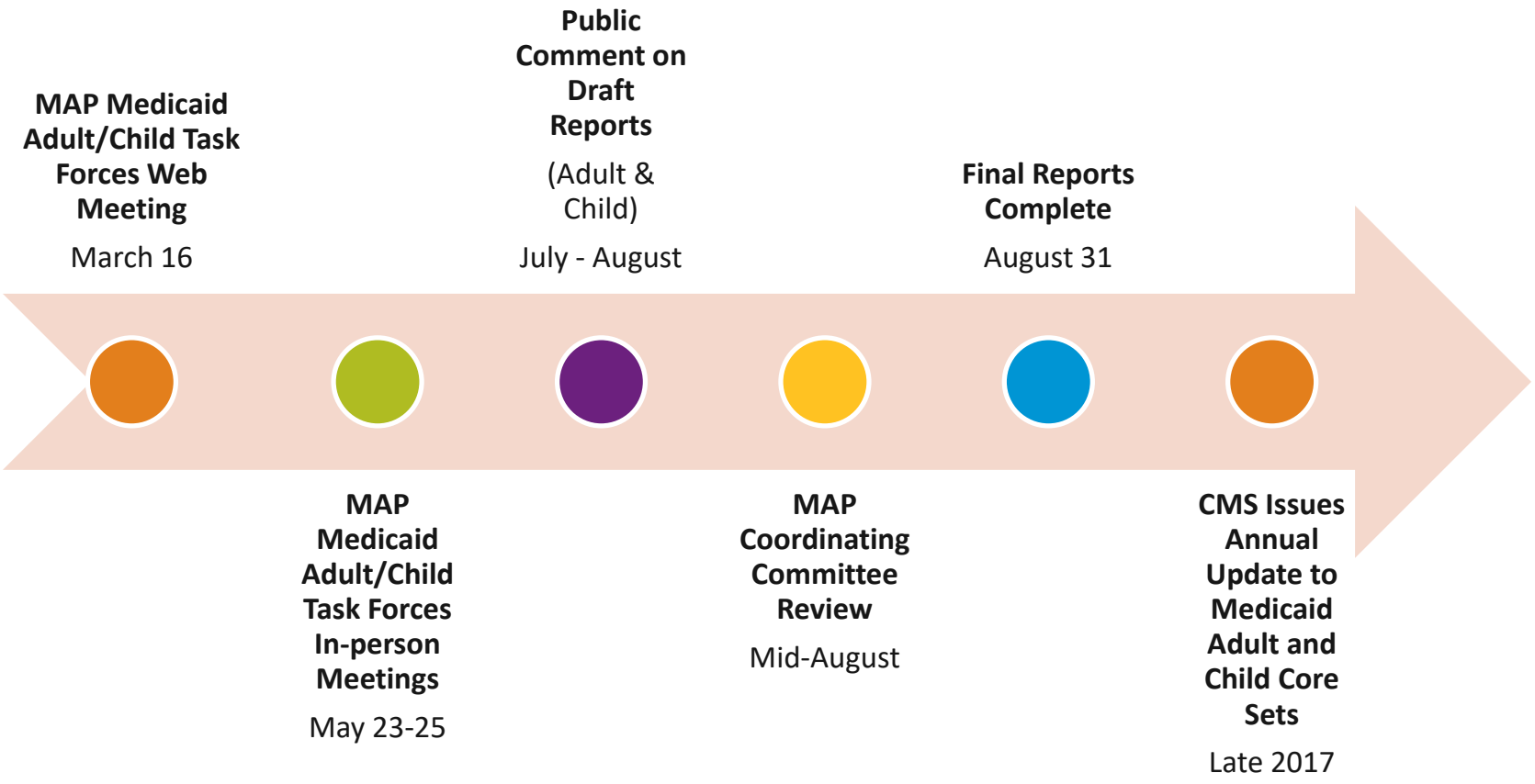
CMS uses core set data to obtain a snapshot of quality across Medicaid and CHIP

- Annual Child Health Quality Report
- Annual Adult Health Quality Report
- Chart pack and other analyses
- Inform policy and program decisions

MAP Medicaid Child and Adult Task Forces Charge

- The charge of the MAP Medicaid Child and Adult Task Forces is to:
  - *Review states' experiences reporting measures to date*
  - *Refine previously identified measure gap areas and recommend potential measures for addition to the set*
  - *Recommend measures for removal from the set that are found to be ineffective*

Medicaid Project Timeline



Medicaid Project Evolution

Goals

- Align with MAP's Measure Review Processes
- Standardize workflow
- Facilitate standardized assessment and recommendations across project years
- Systematically review measures recommended for addition

Medicaid Process Improvement

Process Improvement Documents for Review and Discussion

- Core Set measure recommendations are based on Medicaid population specific gap areas and guided by the Measure Selection Criteria
- Introduce a standardized way of discussing potential measure recommendations based on a Medicaid specific Algorithm and Preliminary Analysis
- Note: the MAP Pre-rulemaking Algorithm and Preliminary Analysis has been adapted for the Medicaid Core Sets

Medicaid Decision Categories

SUPPORT

- Addresses a previously identified measure gap
- Measures that are ready for immediate use
- Promotes alignment across programs and settings

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Medicaid Decision Categories contd.

CONDITIONAL SUPPORT

- Pending endorsement from NQF
- Pending change by the measure steward
- Pending CMS confirmation of feasibility
- Et cetera.

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DO NOT SUPPORT

- Measure and/or measure focus inappropriate or a bad fit for use in the Core Sets
- Duplication of efforts
- Resource constraints
- Medicaid agencies at the state level will need to tweak and or vary the level of analysis to increase measure adoption and implementation.

Medicaid Decision Categories contd.

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Changes to the MAP Preliminary Analysis Algorithm

Additions

- Added Medicaid specific clarification such as “high-impact gap area,” and Medicaid population

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Changes to the MAP Preliminary Analysis Algorithm contd.

Adaptations and Deletions

- Edited Assessment #5 to "operational feasibility" from "reporting feasibility"
  - *Measure can be reported **changed to** measure can be implemented*

- Deleted #7 regarding feedback from current measure users, i.e. if the measure is currently in use
  - *Does not provide Medicaid specific information*
  - *For MAP CC discussion: Should this assessment still be done?*

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Discussion

- Should any other factors and or considerations be added to the Medicaid Preliminary Analysis for assessment?
- Any additional edits?

Opportunity for Public Comment

Lunch

Potential Improvements to the Pre-Rulemaking Process

Round-Robin Plus/Delta

- What worked?
- What could be improved?

MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. However, the measure should meet a condition (e.g., NQF endorsement) specified by MAP before it can be supported for implementation. MAP will provide a rationale that outlines the condition that must be met. Measures that are conditionally supported are not expected to be resubmitted to MAP.
Refine and Resubmit Prior to Rulemaking	The measure addresses a critical program objective but needs modifications before implementation. The measure meets assessments 1-3; however, it is not fully developed and tested OR there are opportunities for improvement under evaluation. MAP will provide a rationale to explain the suggested modifications.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of the assessments.

Holistic Review of Measure Sets

- MAP has expressed a need to better understand the program measure sets in their totality:
  - *How MUCs would interact with current measures;*
  - *Endorsement status of current measures;*
  - *Experience with current measures*
- For the 2016-2017 pre-rulemaking cycle, MAP will offer guidance on measures finalized for use:
  - *MAP will offer input on ways to strengthen the current measure set including recommendations for future removal of measures.*
  - *This guidance will be built into the final MAP report but will not be reflected in the "Spreadsheet of MAP Final Recommendations."*

Provide Feedback on Current Measure Sets

- Consider how the current measure set reflects the goals of the program
- Evaluate current measure sets against the Measure Selection Criteria
- Identify specific measures that could be removed in the future

Potential Criteria for Removal

- The measure is not evidence-based and not linked strongly to outcomes
- The measure does not address a quality challenge (i.e. measure is topped out)
- The measure does not utilize measurement resources efficiently or contributes to misalignment
- The measure cannot be feasibly reported
- The measure is not NQF-endorsed or is being used in a manner inconsistent with endorsement
- The measure has lost NQF-endorsement
- Unreasonable implementation issues that outweigh the benefits of the measure have been identified
- The measure may cause negative unintended consequences
- The measure does not demonstrate progress toward achieving the goal of high-quality, efficient healthcare

Input on improving the review of current measure sets

- How can MAP improve review of current measures sets?

Feedback Loop Pilot

- The goal of the feedback loop is to provide updates based on stakeholder concerns on whether:
  - *a measure has been submitted for NQF endorsement and results of the Endorsement and Maintenance Standing Committee's review;*
  - *a measure is performing as expected; and*
  - *updates have been made to a measure to address MAP conditions of support.*
- This review is not intended to allow for a change in MAP's recommendation about a measure.
- For 2016-2017 Pre-Rulemaking, NQF and CMS pilot tested a "feedback loop" process with the PAC/LTC Workgroup.
- During the October web meeting, NQF and CMS provided updates on the development and endorsement of selected measures.

Feedback Loop Coordinating Committee Discussion

- How can MAP strengthen the feedback loop?

Break

Pre-Rulemaking Cross-Cutting Issues: Risk Adjustment for Sociodemographic Factors

Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs: An Overview of ASPE's Report to Congress

Update on 21st Century Cures Act

Update on the NQF Trial Period for SDS Adjustment

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*

SDS Trial Period Update

- Cost and Resource Use:
  - *The NQF Board heard appeals of its decision to endorse three cost and resource use measures without SDS adjustment.*
  - *The Board voted to uphold endorsement of the measures.*

- Readmissions:
  - *The Executive Committee ratified the endorsement of 17 new and maintenance measures and 15 conditionally endorsed measures.*
  - *Additionally, the EC recommended:*
    - SDS adjustor availability be considered as part of the annual update process;
    - NQF should focus efforts on the next generation of risk adjustment, including social risk as well as consideration of unmeasured clinical complexity;
    - Given potential unintended effects of the readmission penalty program on patients, especially in safety net hospitals, CSAC encourages MAP and the NQF Board to consider other approaches; and
    - Directs the Disparities Standing Committee to address unresolved issues and concerns regarding risk adjustment approaches, including potential for adjustment at the hospital and community-level.

Summary of Data Availability for Social Risk Factor Indicators

SOCIAL RISK FACTOR	DATA AVAILABILITY			
Indicator	1	2	3	4
SEP				
Income		■		
Education		■		
Dual Eligibility	■			
Wealth			■	
Race, Ethnicity, and Cultural Context				
Race and Ethnicity		■		
Language		■		
Nativity	■			
Acculturation				■
Gender				
Gender identity				■
Sexual orientation				■
Social Relationships				
Marital/partnership status		■		
Living alone			■	
Social Support			■	
Residential and Community context				
Neighborhood deprivation		■		
Urbanicity/Rurality	■			
Housing		■		
Other environmental measures				■

1. Available for use now

2. Available for use now for some outcomes, but research needed for improved, future use

3. Not sufficiently available now; research needed for improved, future use

4. Research needed to better understand relationship with health care outcomes and on how to best collect data

Committee Discussion

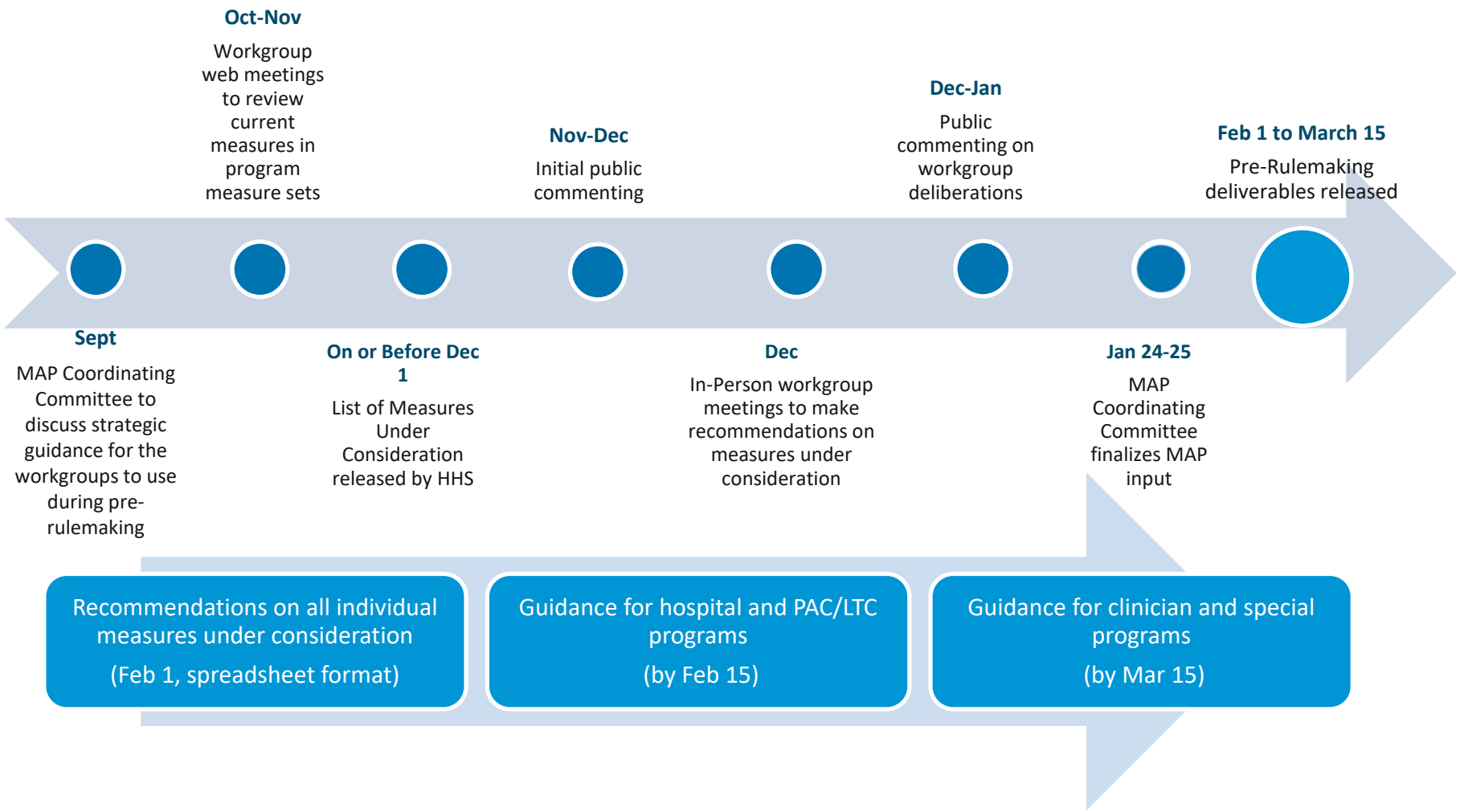
- What are the implications of these findings for MAP's work?
- Does the Coordinating Committee have any guidance on how we can better account for social risk factors?

Discussion

- Should any other factors and or considerations be added to the Medicaid Preliminary Analysis for assessment?
- Any additional edits?

Opportunity for Public Comment

MAP Pre-Rulemaking Timeline



Closing Remarks

Adjourn