NATIONAL QUALITY FORUM

MAP 2016 Cross-Cutting Guidance

DRAFT FOR COMMENT

February 12, 2016

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, Task Order HHSM-500-T0018.

The Patient Protection and Affordable Care Act (ACA) of 2010 required that the U.S Department of Health and Human Services (DHHS) implement an annual federal pre-rulemaking process to provide input and gain consensus on the quality and efficiency measures being considered for public reporting and performance-based payment programs. The Measures Application Partnership (MAP), convened by the National Quality Forum (NQF), was formed in 2011 to serve as the multi-stakeholder entity to serve the role of providing recommendations on the measures under consideration by DHHS.

MAP provides guidance on the selection and use of performance measures in federal programs on multiple levels. First, MAP considers the impact of an individual measure and the value it might have on improving health and healthcare or reducing healthcare cost or resource use. MAP carefully balances these factors with the concerns that a measure might have potential negative unintended consequences or unfairly burden the provider being measured. Next, MAP provides guidance at the programmatic level, using its Measure Selection Criteria to determine how measures relate and work together to address key quality issues and improve the measure set used in a program on the whole by ensuring it meets the elements described in the criteria. A key element of MAP's work to improve the program measure sets has been to identify and prioritize the need for filling gaps in performance measurement. Finally, MAP seeks to encourage further alignment across programs to provide consistency on where performance measurement could have the most impact and give a more complete view of the quality of care delivered across an episode.

MAP used the five-year mark of its establishment to reflect on the changing landscape of performance measurement and federal quality initiatives to identify areas for continued enhancements to the pre-rulemaking process.

Reflections at Five Years

Changes in the Measures under Consideration

Over the past five years, MAP has made significant strides in strengthening the use of measures within federal programs. To date, there are over 1,543 measures that have been submitted for consideration by MAP for use in over 20 federal programs. Of these, nearly 50% have been process measures, and just over one-third has been outcome measures. However, guidance from MAP over the five years has promoted a change in the type of measures submitted for consideration. In 2015, for the first time in MAP's history, more outcome measures were submitted for consideration than process measures. MAP has continued to emphasize the need

to measure outcomes that are important to patients and the shift in the type of measures submitted represents an encouraging direction for the future.

Another important change during the first five years of MAP has been the stage of development that measures are in when they are submitted for consideration. MAP has seen a substantial shift in the number of fully developed measures (e.g., tested) versus the number of measures still under development. DHHS has increasingly looked to MAP to provide upfront multi-stakeholder guidance on measures that are in earlier stages of development. This upfront guidance allows DHHS to ensure there is multi-stakeholder buy-in on the idea of the measure prior to significant investments in testing the measure. In 2015, more than 60% of measures submitted for consideration by MAP were under development and not fully tested. Similarly, less than 30% of measures submitted to MAP have been previously endorsed by NQF. MAP has established itself as a key multi-stakeholder forum that provides guidance on whether measures should be pursued for further development and subsequently implemented in federal quality improvement initiatives.

Changes to the CMS Quality Initiative Programs

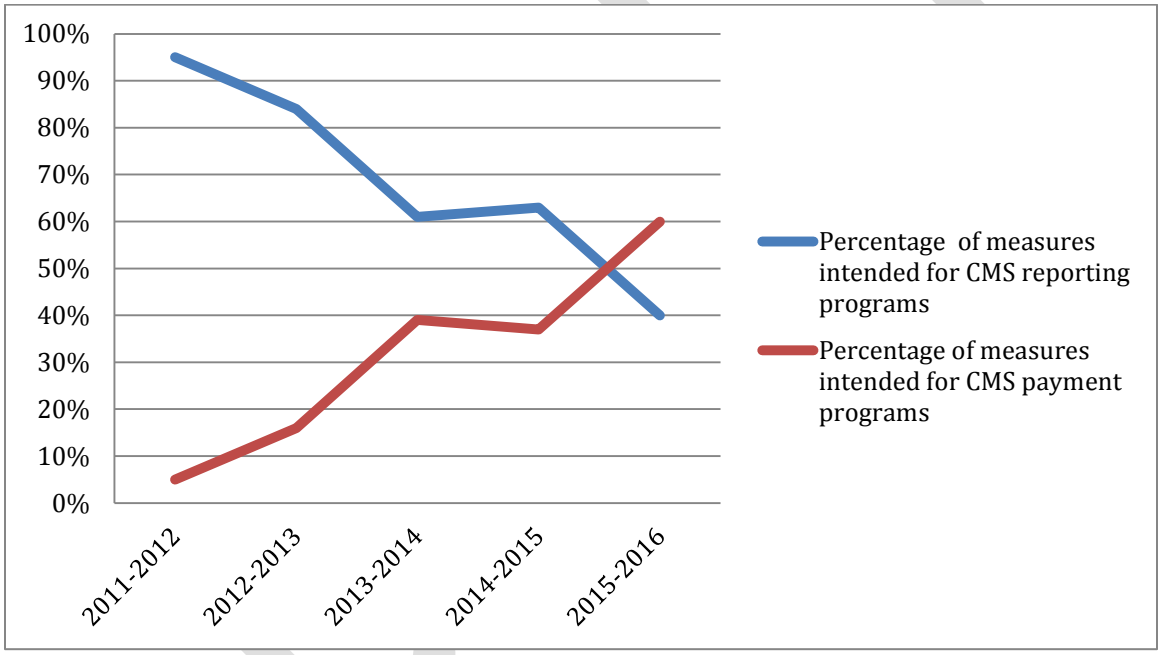
In addition to changes in the performance measures that MAP has evaluated in the past five years, there have been strategic shifts in the nature of the quality initiative programs as well. As noted above, MAP was created by the ACA, landmark legislation that dramatically altered the healthcare landscape. The ACA ushered in the era of value-based purchasing, creating a number of the pay-for-performance initiatives, particularly for hospitals. MAP has had and continues to have an important role in considering measures for these initiatives. DHHS has continued to show its commitment to value-based purchasing, best illustrated by the January 2015 announcement that DHHS has set a goal of tying 90% of all traditional Medicare payments to quality or value by 2018 through its quality initiative programs.

The landscape for federal quality initiatives continues to evolve. MAP noted that the approved Medicare Access and CHIP Reauthorization Act (MACRA) legislation is a prime example of the changing environment as the legislation repeals the Sustainable Growth Rate in an attempt to continue to tie physician payment to value rather than volume. This legislation will have a significant impact on the clinician quality improvement initiatives, consolidating the Value-based Payment Modifier (VBPM), Physician Compare (PC), the Physician Quality Reporting System (PQRS) and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program into a single program: the Merit-Based Incentive Payment System (MIPS). MIPS will evaluate how payments are distributed to providers based on quality of care provided, resource use, meaningful use of EHR technology and clinical practice improvement.

In addition to the changing landscape for clinician programs, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 is another shift in the quality reporting initiatives that influences MAP's role going forward. The IMPACT Act seeks to improve care for Medicare beneficiaries by implementing and standardizing quality measurement and resource utilization for post-acute care providers. MAP noted that increased attention is needed to ensure consistent performance measurement across the various post-acute settings, while acknowledging the challenge that varying data sources may pose in ensuring this consistency.

Accordingly, MAP has seen a shift in the uses for the measures it considers. Figure 1 demonstrates the shift in the intended use of the measures MAP reviews from pay-for-reporting to pay-for-performance.

Figure 1



Impact and Success

Early results show the impact that value-based purchasing can have on health care quality and the influence of MAP's recommendations. Since the introduction of the Hospital Readmissions Reduction Program (HRRP), readmission rates have dropped below 18%.[1] MAP supported the measures currently used in this program. The Medicare Payment Advisory Commission (MedPAC) reported that the reduction for conditions subjected to HRRP was greater than the reduction for all causes.[2] MAP was also instrumental in making recommendations for the measures used in the Hospital Acquired Condition (HAC) Reduction Programs. MAP was

supportive of using the Center for Disease Control and Prevention's (CDC) National Healthcare Safety Network measures and the Agency for Healthcare Research and Quality's Patient Safety for Selected Indicators composite measure. Rates of HACs have declined 17% from 2010 to 2014, a change from 145 to 121 HACs per 1,000 discharges. Because of this, patients experienced 2.1 million fewer HACs and 87,000 lives were saved. Additionally, this reduction in HACs translates into approximately $20 billion in savings.[3]

Goals for the Future

MAP continues to reaffirm its mission to recommend measures that address the most important areas for improvement. MAP is committed to continually enhancing its pre-rulemaking process to ensure it is delivering recommendations that will improve health for all Americans. In the pre-rulemaking cycle for 2015-2016, MAP initiated a number of key processes to strengthen how it makes its recommendations.

Impacting Health and Healthcare

MAP recognized the need to ensure the measures it recommends will have an impact on improving health and healthcare. MAP established a two-pronged approach for assessing the impact of a measure. Impact was first considered as how the measure relates to measures currently included in the program's measure set and how the measure relates to the program goals. The second approach was to assess the improvement in health resulting from the use of the measure. MAP reiterated that the goal of measurement is to assess performance and drive improvement with the overall goal of improving health. This includes considering the relationship to patient outcomes, the opportunity for improvement, and the disease burden in the measured population.

MAP took a broad view of improving health, including considering if a measure could improve population health or could lower cost and resource use by improving quality. MAP recognized that a broad perspective is needed to consider if a performance measure has impact. MAP also noted that impact involves weighing the value of a measure against the burden of implementing and using it, and the potential for negative unintended consequences to patients.

MAP recognized that the impact of a measure can largely depend on how it's intended use, for example quality improvement, public reporting, or pay for performance.. A good measure will have little impact if its results do not drive behavior change. A measure needs to be considered within the context of the program in which it will be used and assessed for how it meets the goals and requirements of the program. MAP also noted the need to consider the intended use of a measure. A measure that might help a provider improve performance may not help a consumer to select a provider.

MAP noted that better information is needed to truly assess if a measure has impact. MAP has continually pushed to make its recommendations more evidence based and has reiterated the need for better data to support its decision making. To obtain this information, MAP called for better partnerships with those in the field using measures who can share how implementation of a measure drives results, or conversely, if the implementation of a measure has negative unintended consequences. Such partnerships could provide better information about which measures are adding value and which measures are simply adding burden.

To better understand the potential impact of a measure, MAP identified the need for several future multi-stakeholder measurement science efforts. First, MAP called for guidance around program implementation to develop a better understanding of how a measure fits within the structure of a program. For example, MAP makes recommendations about whether an individual measure should be included in the program but there is little multi-stakeholder input into issues such as how a measure is weighted a program's scoring algorithm which can significantly alter the score a provider receives. MAP agreed that future work is needed to define key measure attributes and program attributes, examine their interaction, and give program implementers guidance on which measures may be better suited for implementation in specific programs based on program characteristics. Finally, a number of questions about data sources emerged during this year's pre-rulemaking process. MAP identified several measures under consideration that were submitted using multiple data sources (e.g., e-measure specifications, and specifications using administrative claims). MAP noted that a better understanding of how these different data sources impact performance measure results is needed.

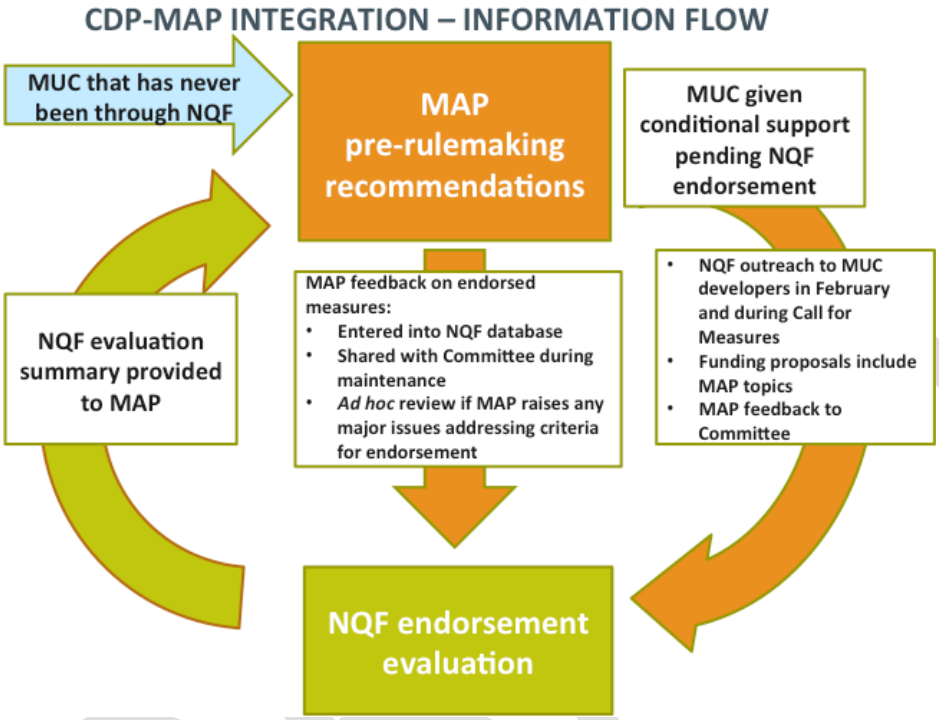
Ensuring Scientific Integrity: Better Alignment between Measure Endorsement and Selection

MAP depends on the NQF Consensus Development Process (CDP) measure endorsement process to ensure that there is sound testing and robust evidence to support the measure focus. However, as MAP continues to review measures earlier in their lifecycle, there is also a need to ensure that MAP's recommendations are shared with the NQF Standing Committees and Consensus Standards Approval Committee (CSAC) as they make their endorsement decisions.

These interdependencies require a seamless flow of information between the two processes. MAP noted measures are often conditionally supported pending NQF endorsement; the relevant Standing Committee considers feedback from the MAP when the measure is submitted for endorsement. Further, insight gained by the MAP on the pipeline of measures under development can help to inform future endorsement projects. Finally, information from the

CDP process should circle back to the MAP once the NQF endorsement process has completed the measure evaluation. The MAP recognized that while funding and timing constraints may exist, an increased focus on tighter information flow with the endorsement process is critical to the future work of MAP.

Figure 2: CDP-MAP Information Flow



Aligning Program and Measure Attributes: Considering Intended Use

MAP reviewed the input of NQF Intended Use expert panel that deliberated on how the intended use of a measure should be considered in the NQF Consensus Development Process for measure endorsement. The Expert Panel did not recommend including the specific use of a measure in the endorsement process noting that there is limited evidence that a measure needs different levels of evidence or testing to be used for different purpose (i.e. public reporting or pay for performance). However, the Expert Panel did recommend the development of an "NQF+" designation for measures that meet the highest levels evidence and testing to ensure this information is transparent to measure users. The Panel encouraged MAP to consider how the "NQF+" designation can be used when selecting individual measures for specific programs. For example, in an effort to align program and measure attributes, the MAP may determine that an individual program requires "NQF+" measures.

MAP discussed the need to apply the "NQF+" designation in its future work. MAP noted the recommendation of the Expert Panel to examine key measure and program attributes and their interactions to help inform MAP recommendations. The MAP Coordinating Committee will continue to refine its approach to using the "NQF+" designation as this change is implemented in future NQF measure endorsement efforts.

Clarifying Priorities

MAP noted the need for explicitly stated priorities across its workgroups to understand how well the measures under consideration and measures currently in the programs address the key areas where MAP would like to drive quality improvement. The MAP Core Concepts would be a set of priorities that that would cut across the MAP workgroups and the programs they review. This set of priorities would allow MAP to systematically assess progress and ensure that the most important areas of improvement are measured in the Centers for Medicare and Medicaid Service's (CMS) quality initiative programs. These priorities would also allow MAP to look more holistically across settings and consider important issues across the continuum of care.

Using the MAP Core Concepts as a framework can help integrate and summarize measurement gaps while allowing their evolution to be tracked over time and illuminating where gaps exist across high leverage areas, disease states, and programs. This framework would also help to show the impact of a measure and support alignment. Working with a shared organizing framework would give MAP a better understanding of how a measure could help address a problem while providing a clearer picture of where the gaps are to allow better progress towards a solution.

To ensure collaboration with CMS around a shared strategy and framework, MAP will build its core concepts around the CMS Quality Strategy. The CMS Quality Strategy aligns with the three broad aims of the National Quality Strategy (NQS) and its six priorities. The NQS has served as the foundation for MAP's work; however there is a need to better operationalize the NQS in the MAP pre-rulemaking process. The MAP Core Concepts build on the goals of the CMS Quality Strategy:

- Making care safer
- Strengthening person and family engagement
- Promoting effective communication and coordination of care
- Promoting effective prevention and treatment
- Working with communities to promote best practices of healthy living
- Making care affordable

MAP will also adopt the objectives CMS has established to achieve these goals. However, the MAP Core Concepts would seek to operationalize these goals by adding areas of focus to each CMS objective. The objectives would show what MAP is trying to achieve; the areas of focus would show how MAP will do so. The areas of focus will represent the measurement topics MAP will seek to promote across programs. The Core Concepts and Areas of Focus will serve as a tool to evaluate measures under consideration and identify gaps going forward. A measure under consideration will be more likely to gain MAP's support if it addresses an area of focus.

Table 1: Example of the MAP Core Concept Framework

NQS Priority	MAP Core Concept/CMS Objective	Example Areas of Focus
Strengthen Person and Family Engagement	Ensure care delivery incorporates patient and caregiver preferences	Shared Decision Making Experience of Care
	Improve experience of care for patients, caregivers and families	Physical Functioning Mental/Behavioral health Patient reported pain and symptom management
	Promote patient self-management	Care Matched with Patient Goals Establishment of patient/family/caregiver goals Advanced care planning and treatment/palliative and end-life care Patient Centered Care Planning

MAP will continue to develop its Core Concepts for the 2016-2017 pre-rulemaking cycle.

Filling Measurement Gaps

The identification of measurement gaps in each program the MAP reviews has been a fundamental part of the MAP pre-rulemaking process. However, the current process makes it difficult to interpret and prioritize gaps. MAP recognized the need to refine its process to develop clearer priorities that are applicable across both public and private programs. MAP needs to look across programs and make recommendations that can improve health and healthcare nationally and across populations. In the future, the MAP Core Concepts will serve as a set of shared priorities to better identify gaps, sending stronger signals about where measure development is needed, allowing MAP to track progress in gap filling. The Core Concepts will give MAP a better idea of how a measure could help drive progress.

MAP noted a key gap of cross-cutting measures that assess care across settings, providers and time. MAP stated the need to hold clinicians, hospitals, and post-acute care settings all responsible for the quality of a patient's care as a person moves through an episode of care. The Core Concepts will help to ensure that all parts of the care continuum are working to improve care in key areas.

MAP recommended exploring ways current measures could be expanded to fill gaps. As noted above, the Core Concepts will allow for easier comparisons of where measures currently exist to assess priority areas and how these measures could be updated to fill gaps in other settings.

Promoting Alignment

The MAP Core Concepts will allow high value measure concepts to be identified across programs, thus serving as a tool to promote alignment. While alignment is frequently interpreted as using the same measure across programs, MAP recognized that this is not always feasible. Differences in measure specification based on available data sources and levels of analysis can make implementing the same measure impossible in different settings. The Core Concepts will provide consistency on where performance measurement could have the most impact and give a more complete view of the quality of care delivered across an episode. Using its Core Concepts to promote alignment will allow MAP to send a clear message about the priorities and expectations shared by multiple stakeholders across public and private programs. Increased comparability across settings and levels of analysis will also make quality information more valuable for consumers, purchasers, and payers.

MAP established a set of goals for alignment. MAP stated that alignment should:

- Reduce redundancy (i.e. duplication of measures)) and strive towards a comprehensive core measurement approach
- Send a clear and consistent message regarding the expectations of payers, purchasers, and consumers
- Reduce the costs of collecting and reporting data
- Enable comparison of providers
- Transform care in priority areas with notable potential for improvement
- Avoid confusion on the part of all stakeholders

MAP raised a number of cautions about alignment of measures. First, MAP cautioned that it is important to balance the needs and goals of an individual program with the goal of alignment. MAP noted that not all measures will be right for all programs; rather, a measure may address a critically important issue for one program or setting. Alignment should also not be a reason to

limit innovation. MAP recognized the need to weigh the benefit of alignment against the benefit of a new measure.

Finally, MAP noted a number of barriers to alignment that should be addressed including concerns about unnecessary variation in definitions, limited interoperability of electronic health records, and discrepancies in how measure are being used, in particular concerns about differing specifications of NQF-endorsed measures.

2015-2016 Pre-Rulemaking Input

MAP built upon the lessons of its past and its vision for the future when developing its 2015-2016 pre-rulemaking recommendations. As MAP reviewed 141 measures for 16 federal programs, a number of key issues arose across the settings. Noting the increasingly high-stakes of performance measurement, MAP cautioned that measure results should be properly attributed, and measures should be appropriately risk adjusted.

Attribution/shared accountability,

As the U.S. healthcare system increasingly shifts to a performance-based payment system, MAP noted the importance of identifying the appropriate accountable entity that can be held responsible for patients' care and encouraging shared accountability for patient outcomes. MAP continues to encourage programs to shift from assessing process of care to measuring care outcomes that are important to patients and their families. However, MAP noted that measuring care outcomes raises an important measurement challenge, specifically the issue of appropriate attribution of these outcomes to providers. MAP continues to encourage shared accountability across providers for important patient outcomes; however, the MAP found it challenging to define how to appropriately assign patients and their outcomes to multiple organizations and providers who often have a role in influencing these outcomes.

There are several illustrative examples that help to demonstrate the importance of the attribution issue. The use of 30-day readmission measures, mortality measures, or episode-based payment measures place a significant responsibility for the patient's unplanned post-discharge care specifically on acute care hospitals. This highlights the need to develop guidance on the appropriate approaches to attribution. Another example of the attribution issue can be seen with clinician-level measurement for public reporting and pay-for-performance programs. With an increasing emphasis on team-based care that includes primary care physicians, specialists, nurse practitioners, and other clinicians, it may be challenging to hold an individual clinician responsible for a patient's health outcome. Finally, MAP noted that important population health goals, such as smoking cessation, should be advanced through the various federal programs. However, improvement of population-level smoking rates cannot be the sole

responsibility of one provider. MAP noted that a balance is needed when encouraging providers to take a greater role in improving population health goals while recognizing of the limits of an accountable entity's control in improving the population health outcome.

MAP cautioned that measures and programs need to recognize that multiple entities are involved in delivering care, and there is an individual and joint responsibility to improve quality and cost performance across the patient episode of care. MAP encouraged a multi-stakeholder evaluation of these attribution issues to provide the field guidance on theoretical and empirical approaches to attribution that can be used to guide the selection of measures for federal programs. The development of this guidance should raise the issue above an individual measure and provide guidance across measure development, endorsement, selection and use.

Disparities and Socio-demographic Status (SDS) Adjustment

MAP strives to reduce disparities in health care through the selection of measures that identify inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate linguistic access, among other contributing factors to healthcare disparities. MAP noted that all members of the health care community have a role in promoting appropriate treatment of all patients by identifying and addressing the factors that lead to disparities in health outcomes.

MAP continues to support the two-year SDS trial period undertaken by NQF. This trial period will allow measures undergoing review for endorsement to be examined for whether the measure has a conceptual and empirical basis to include SDS factors in their risk adjustment model. 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 its recommendations will help to reduce healthcare disparities. The DSC is charged with developing a roadmap for using quality measurement and associated policy levers to proactively reduce disparities. The DSC will be able to provide MAP with strategic direction and guidance, while supporting measure development activity and growth of the NQF portfolio of measures addressing disparities and cultural competency.

Maintaining MAP Recommendations

MAP discussed the need to develop processes to maintain the integrity of its recommendations. First, MAP stated the need to learn about the experiences of those implementing the measures that MAP is reviewing. MAP members noted that users with experience with measures in the field can help identify trends in measures' overall performance, or variation in performance. Further, those with measure use experience can provide guidance on the specific interventions that lead to performance improvement, share information on whether the measure is having the intended effect, and help MAP understand the extent to which the measure is being used. As a starting place to gaining this insight, MAP encouraged feedback to MAP's enhanced public commenting process so users can share their experiences with the measures under consideration. Additionally, MAP noted the need to gather information about the measures after they are implemented within programs to ensure the measures are feasible (e.g., can be implemented without undue burden) and to determine whether the measures result in any unintended consequences.

In addition to enhanced connections with measure users to understand their implementation experiences, MAP noted the importance of the multi-stakeholder review of measures as they are refined and implemented. First, MAP noted that recommendations for measures under development should be revisited once the measure is fully developed, specified, and tested. MAP appreciates the opportunity to provide upfront guidance to CMS on measures as they are being developed but emphasized that downstream multi-stakeholder review of measures is critical. Once a measure is fully developed a multi-stakeholder review will ensure that measures are achieving their intended purpose and are improving health and healthcare. Secondly, MAP noted the need to review measures after they are implemented. MAP emphasized a need to review its decisions in light of guidance from the CDP process and insights from measure users as noted above. MAP and CMS agreed future efforts should be undertaken to examine how best to implement such a process.

Conclusion

MAP's 2015-2016 pre-rulemaking recommendations provide guidance to DHHS on the use of 141 measures in 16 federal programs. In this cycle, MAP focused on ways to improve its decision making abilities. MAP clarified its guidance around a number of key issues, impact, gaps, and alignment, to confirm it is making recommendations consistently. MAP also identified several key cross cutting issues across the various workgroups, including attention to disparities and socio-demographic adjustment, the need for guidance on appropriate attribution, and the need for information on measure implementation experience. These enhancements to the pre-rulemaking process will help ensure MAP's recommendations drive

progress on the most important quality issues while preventing undue measurement burden on the healthcare system.

MAP will continue to work to improve the pre-rulemaking process. MAP noted the need to establish its priorities through the development of its Core Concepts. MAP will use these Core Concepts in the future to develop recommendations on measures under consideration and identify outstanding gaps in the programs. MAP will continue to develop ways to get implementation experience about the measures under consideration from those currently using the measures. Additionally, MAP will continue to align its work more closely with that of the CDP to ensure that information flows seamlessly between the processes.

References:

[1] U.S. Department of Health and Human Services. (7 May 2014). New HHS Data Shows Major Strides Made in Patient Safety, Leading to Improved Care and Savings. http://innovation.cms.gov/Files/reports/patient-safety-results.pdf

[2] MedPAC. Report to the Congress Medicare and the Health Care Delivery System. http://www.medpac.gov/documents/reports/jun13_entirereport.pdf

[3] Saving Lives and Saving Money: Hospital-Acquired Conditions Update Interim Data From National Efforts To Make Care Safer, 2010-2014