

# Building Bridges among the National Quality Forum, Medicaid, and Other State Stakeholders

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# Table of Contents

Executive Summary .....	3
I. Overview .....	5
II. Methods .....	6
III. Themes from Medicaid Leaders.....	6
IV. Themes from Public Health Leaders .....	12
V. Themes from Health Insurance Commissioners .....	13
VI. The State of State Capacity .....	14
VII. Recommendations for NQF.....	15
Appendix A: List of Key Informants .....	18
Appendix B: Interview Protocol .....	19

## Executive Summary

The National Quality Forum (NQF) has spent more than a decade engaging patients, clinicians, health care purchasers, providers, communities, health plans, and others to reach consensus on performance standards for safe, high-quality health care. Through its National Priorities Partnership (NPP) initiative, NQF is also developing a framework that reflects a shared vision for improving health and health care across public and private sectors of the health care system.

However, to date, NQF’s measure endorsement and priority-setting activities have lacked meaningful engagement with state entities. As NQF positions itself to respond to both the Affordable Care Act (ACA) and the American Recovery and Reinvestment Act (ARRA), its success will depend on its ability to gain traction with state Medicaid programs, state departments of insurance and public health. Medicaid is the nation’s largest health coverage program, spending more than \$360 billion annually in purchasing care for 60 million individuals in the U.S. With the recent passage of health reform, Medicaid will cover an additional 16 to 18 million Americans, starting in 2014. With that expansion, Medicaid will provide health insurance to a quarter of the nation’s population. Given its sheer size and its continuing transformation from a bill payer to an active health care purchaser, Medicaid – and the emerging state exchanges that will cover an additional 16 million Americans – can play a key role in supporting nationally endorsed performance measures. Public health entities should also serve as crucial measurement partners to ensure that access to quality health care translates to improved health outcomes, particularly for vulnerable populations.

Through support from the National Quality Form (NQF), the Center for Health Care Strategies (CHCS) sought to understand how NQF could better incorporate state perspectives into its measurement endorsement and priority-setting efforts. This report outlines themes culled from interviews with 23 key informants, including state Medicaid officials, insurance commissioners, administrators of public health, and national health policy experts.

In addition to presenting insights regarding the unique priorities, populations, and infrastructure issues germane to state-level quality measurement, the interviewees provided critical suggestions for NQF related to programmatic scope, organizational culture, and communication.

Following are the resulting key recommendations for NQF that are detailed in this report:

<b>Recommendations for the National Quality Forum</b>
1. Develop a measurement endorsement agenda that includes both populations and services that are more reflective of state-based programs.
2. Develop a state-level strategic quality measurement dashboard that reflects the health care system in total as opposed to individual components of the health care system.
3. Bridge the health care system and public health by identifying population-based measures for which the health care system can be held accountable.

<b>Recommendations for the National Quality Forum</b>
4. Convene a focused, strategic working group of states to help build the quality measurement dashboard.
5. Function as a national bully-pulpit to advance a value-driven purchasing agenda for state purchasers. Hold states publicly accountable for their use of an NQF <i>Medicaid Community Dashboard</i> .
6. Determine whether NQF should maintain measure specifications or “spin off” an organization responsible for developing and maintaining measure specifications.
7. Build an organization receptive to state needs, which may necessitate new models of funding and staffing and an organizational culture that looks outside the beltway.
8. Develop targeted information for states about NQF’s mission, its functions and programs; how it differentiates itself from other measurement bodies such as NCQA; and how it coordinates with agencies within the Department of Health and Human Services, specifically AHRQ and CMS.
9. Recognize that working with states necessitates a new funding model.
10. Don’t wait for states to join you. Cultivate an aggressive outreach campaign to Medicaid, public health, and insurance department officials.

The authors appreciate the valuable insights from the interviewees and thank them for their commitment to improving health care quality and outcomes for Americans enrolled in publicly-financed care.

## I. Overview

The advancement of health care quality at the state level is currently in a paradoxical situation. Governors across the country are expressing their desire to purchase value- and outcomes-based health care services.<sup>i</sup> Yet, simultaneously states are facing perilous budget dilemmas, with most cutting eligibility for state-funded health programs, slashing provider rates and services in Medicaid, and decimating personnel budgets for departments of health, human services, and insurance.<sup>ii</sup> Viewed through this lens, the picture of health care quality at the state level could look quite bleak indeed. However, advancing the lens a few frames reveals a different scenario. State purchasing power is growing. Currently, Medicaid is the nation's largest health coverage program, spending more than \$360 billion annually in purchasing care for 60 million individuals in the U.S. With the passage of health reform, the program will soon serve up to 80 million, or well more than a quarter of all Americans.<sup>iii</sup> In addition, the state-based insurance exchanges could cover an additional 16 million individuals once fully implemented. In sum, "states are where the opportunity is" to influence the delivery of quality health care services in the U.S.

States will not only play a key role in the implementation of the Affordable Care Act's (ACA) coverage policies, but states also face tremendous opportunities to redesign how they purchase care – transitioning from purchasing units of care to purchasing integrated, evidence-based, outcome-driven care. Several vehicles within ACA provide states (particularly Medicaid) with this opportunity, including: (1) the creation of the Center for Medicare and Medicaid Innovation, which also houses the Federally Coordinated Health Care Office responsible for improving care for people dually eligible for Medicare and Medicaid; (2) payment and delivery system reform opportunities, such as pediatric accountable care organizations, global payment demonstrations, and a state option to provide health home services; and (3) heightened attention on a national quality strategy and stakeholder process and the need to institute new quality measures for adults in Medicaid similar to the child health measures required under the Children's Health Insurance Program reauthorization. In addition to these considerations, states are consumed with how to best implement the HITECH provisions within the American Recovery and Reinvestment Act (ARRA) to advance the use of health information technology and health information exchange.

It is within this dynamic and changing state-based environment that the National Quality Forum (NQF) looks to build bridges between its work and that of state departments of insurance, health, and Medicaid. With or without health reform, states will still need to show the value of the vast public dollars being spent on health care. NQF can provide a national picture of how to measure such value. From the state view, the NQF has built a solid reputation of being the "gold standard" for the endorsement of national, standardized measures. However, in order to better meet the needs of state health care purchasers and administrators of public health services, NQF needs to further shift its focus to: (1) be more inclusive of the populations and services that are provided through publicly financed programs; (2) go beyond simply endorsing measures to provide a strategic quality measurement framework that cuts across the

public health and health care system; and (3) function as a national bully-pulpit to advance a value-driven purchasing agenda for state purchasers.

## II. Methods

The NQF contracted with the Center for Health Care Strategies (CHCS) to conduct interviews with key state stakeholders to identify levers through which NQF can incorporate state perspective, including insurance and public health concerns, in its measure endorsement and priority-setting agenda. State Medicaid leaders were the primary audience due to the size and importance of the Medicaid program. However, state insurance department executives were also interviewed because of their potential role in the administration of the state-based health insurance exchanges, as were public health administrators due to the desire of NQF to bridge population health and health care measurement strategies. In total, CHCS interviewed 23 key informants, including eight state Medicaid officials, three commercial and/or Medicaid health plans, two state insurance department officials, four leaders of state health departments, and six policy experts from academic, provider, and/or consumer communities (see Appendix A for a list of all key informants). Individuals were selected based on state size and geography, knowledge of NQF, and experience implementing quality measurement programs. Early, mid and late adopters were selected. CHCS developed an interview protocol to serve as an informal guide to the interview/discussion (see Appendix B). Individual interview responses are confidential, but their collective thoughts and recommendations are included in this report.

## III. Themes from Medicaid Leaders

### 1. *NQF is the gold standard for measures; but it functions mostly as a clearinghouse of measures, without a meaningful footprint in the Medicaid world.*

Medicaid leaders clearly see the value in having the “NQF Gold Seal of Approval” related to measure selection. Interviewees appreciated having measures vetted and approved by a national standard setting organization, which also means that states do not need to replicate this consensus process. In addition, NQF has a strong and solid reputation within the clinical community; therefore, NQF-endorsed measures appear to be more rapidly accepted by local physicians and other providers.

State Medicaid leaders often “do not know which measures are NQF measures.”

State Medicaid leaders, however, often “do not know which measures are NQF measures.” Given that Medicaid programs have a long history of measuring managed care performance, states are very familiar with Healthcare Effectiveness and Data Information Set (HEDIS) measures developed by National Committee for Quality Assurance (NCQA). States have much less experience measuring hospital and/or ambulatory care performance. Those that do, recognize measures developed by the Agency for Healthcare Research and Quality (AHRQ) or those used by local Aligning Forces for Quality (AF4Q) programs. But, as one interviewee

noted, “NQF loses its branding after awhile.” Enhanced marketing by NQF of its endorsed measure set could fill this information vacuum.

Given NQF’s interest in making its products and technical assistance more relevant to state purchasers, including Medicaid, it will need to assess ways to better select and contextualize measures and engage with Medicaid leaders. Partly due to lack of knowledge of all NQF measures and partly because of the lack of NQF measures focused on Medicaid populations, one interviewee noted, “NQF is a reference point for us, not a starting point.”

**2. NQF can help move the measurement world to consider the 60 million Medicaid-covered lives and their complex conditions.**

Although NQF is highly regarded for its non-partisan, evidenced-informed, consensus-based endorsement process, interviewees across-the-board felt that NQF has not yet endorsed measures that are fully reflective of the Medicaid population and/or services the program covers. One interviewee noted bluntly, “NQF has 600 measures, but the measures are niche measures

“NQF has 600 measures, but the measures are niche measures driven by certain professions which have proprietary interest.”

driven by certain professions which have proprietary interest.” Medicaid stakeholders desperately want NQF to plant a stake in the ground (in terms of national priorities and measures) for “vulnerable populations” and then perhaps other research entities, measurement developers, and the federal agencies would take note. These statements not only represent the frustration of Medicaid leaders, but also show the influence they believe NQF could have in helping to advance a priority-setting and measurement agenda for 60 million Americans.

Medicaid covers some of the sickest and poorest Americans. Given health reform’s coverage expansion, Medicaid will become a universal insurance program for all Americans up to 133% of federal poverty level. Medicaid’s diverse populations include infants and children, pregnant women, low-wage working adults, adults with disabilities, and aging seniors dually-eligible for Medicare and Medicaid. Medicaid beneficiaries have diverse illnesses, conditions, and experiences with the health care system; they also receive care in a wide array of environments, such as Federally Qualified Health Centers, rural health clinics, long-term care facilities, nursing homes, and home- and community-based settings. Stakeholders want NQF-endorsed measures that adequately cover this broad array of needs, have a real impact on people’s lives, and can help people get out of poverty and/or recover from an illness or disability.

The top five reported measurement needs of Medicaid leaders include:

- **Mental health and substance abuse** – moving beyond depression and capturing more severe and persistent mental health conditions, developmental disorders, and alcohol and drug disorders among children, youth, and adults.
  - “I would guess that NQF panels on mental health don’t talk about people with serious mental illness....mostly just depression.”

- “A big gap area is mental health. We spend lot of money on it in Medicaid and we don’t know what we are paying for or what works.”
- **Care coordination and care transitions** – concentrating particularly on patients moving through the acute, behavioral, and long-term care settings.
  - “There is a gap in looking at care transitions for people who have physical, behavioral, and intellectual challenges or disabilities.”
- **Multiple comorbidities** – focusing on patients with multiple physical, chronic, and behavioral health conditions and the interaction of treatment between such conditions.
  - “We are focusing on root causes of multi-morbid folks. What are similar behaviors and interventions across those conditions?”
  - “What about someone who is a schizophrenic, diabetic, homeless smoker? Is there a way to look up a measure for that? Not that I know.”
- **Patient-reported experience and health/functional status** – understanding how patients view their own health and functional status as key determinants of health care needs.
  - “CAHPS is a point in time and can only be collected once. How do we get a more continuous measure instead of doing it after the fact?”
  - “60-70% of people with high health care utilization say that people have told them or that they think that they have a behavioral health issue.”
- **Population health measures** – developing individual measures that are not tied to a clinical process, but rather reflect the health status or behaviors of a population, such as smoking, obesity, dental caries, adverse childhood events, and related “never events” such as babies born with HIV or a smoking pregnant woman.
  - “I think we should all move to England where they link public health and health care and hold people accountable for it all.”
  - “We need measures more than just about individual health. We need to pay attention to population health before medical care often times”

“I would guess that NQF panels on mental health don’t talk about people with serious mental illness...mostly just depression.”

In addition to specific clinical and health needs, interviewees noted the complex set of conditions in which Medicaid beneficiaries are born, grow, live, work, and age. Population health models suggest that clinical care makes up only 20 percent of the health factors that impact mortality and morbidity -- the remaining 80 percent consist of social determinants of health.<sup>iv</sup> These social determinants of health include: (a) health behaviors (e.g., tobacco use, unsafe sex, diet, and exercise); (b) social and economic factors (e.g., income, education, employment, and family support); and (c) the physical environment (e.g., air quality, built environment). Medicaid needs tools that can assess these determinants for:

- Further insight into such upstream variables that present later in the form of sick and costly patients; and
- Risk-adjustment of clinical measures.



Interviewees recommend that NQF readjust its focus from a narrow emphasis on clinical processes and outcomes (e.g., lipid profiles and glycemic control) to more broadly monitoring events such as residential instability, substance abuse, poor diet, and low reading comprehension – all of which have cumulative and long-term impact on health system utilization and the health status of individuals. One Medicaid health plan executive noted, “We are good at risk adjusting for medical comorbidities ... but how do you do it for domestic violence and poverty? We need to be able to do it because it impacts how people deal with health issues.”

### 3. *States do not necessarily want more measures, but better measures.*

Interviewees cautioned NQF against simply increasing the number of measures, but instead encouraged the strategic addition of richer measures in domains such as systems capacity, integration of services, and population-based outcomes. Given the complexity of individuals covered by Medicaid, their multiple health care needs, and the different health care settings they use, this could translate into an opportunity for NQF to develop a more versatile set of cross-cutting measures that go beyond disease specific process and outcome measures.

States noted the importance of Medicaid’s ability to measure system capacity, particularly around access. This should not be surprising given historical problems of access in Medicaid and the need to ensure that the state health care system -- with the Medicaid expansion and exchange populations -- can absorb up to 32 million new patients in 2014. Interviewees noted the need for systems or structural capacity measures including: (a) *access*, such as waiting times, time to 3<sup>rd</sup> appointment, and after-hours appointments; (b) *workforce*, such as clinical staff capacity and retention, and team coherence and functioning; and (c) *continuity of care*, such as having a sustained relationship between a patient and physician. As one interviewee noted, “We look at whether person has been assigned to a primary care physician (PCP). We look at specialty to PCP ratio. We’ve spent embarrassingly little time on engagement and continuity. We can fix appointments and get them to come once, but not again.”

“We and the state are committed to integrated populations solutions, regional authorities, and global funding in a region for all-state supported programs.”

States also want to focus on broad, system-wide solutions that consider both: (a) the integration of health care services, such as physical health, behavioral health, oral health, and long-term care; and (b) the linkage between health care and population health. One state official noted: “We and the state are committed to integrated populations solutions, regional authorities, and global funding in a region for all-state supported programs.” A challenge – and additional incentive – to taking a whole-system view in Medicaid is that many beneficiaries are served by multiple state agencies; one example is children in child welfare. These are high-cost, high-need children who receive services from Medicaid, mental health, child and family services, and juvenile justice entities. NQF measures that took a holistic view of care delivery and associated social and clinical outcomes for children could in turn spur states to create inter-agency systems

of care and data sharing that might facilitate longer term measurement and quality improvement efforts.

Medicaid officials also noted the need for more population-based outcome measures. This includes not only disease-specific mortality measures, but also indicators of morbidity such as burden of disease and quality of life. States highlighted the need for: (a) measures related to functional status, such as impaired vision, mobility, or cognition, particularly given the range of disabilities and complex illness among Medicaid enrollees; and (b) measures cutting across the lifespan, such as looking at a woman's health before and after childbearing years, not just during pregnancy.

**4. Medicaid programs want a deeper dive on measures and the ability to benchmark their performance relative to other Medicaid purchasers.**

One interviewed noted "NQF endorses measures, but it does not insist on clearly defining numerators and denominators. [Is this] perhaps because the measures are proprietary?" Quality staff in state Medicaid programs who are

**"Someone has to do measure specification and maintenance of measures."**

responsible for operationalizing measures in both the managed care and fee-for-service payment environments want better measure specifications down to the diagnosis and procedure code level. States are frustrated by the staff time devoted to maintaining measures and by their inability to "get the measures perfect." For example, denominator size is an issue when considering subpopulations with extreme health needs but low volume, such as children with HIV/AIDS. States reported the need for technical assistance in understanding the kind of statistical parameters required to make applications of these measures meaningful.

Such operational detail for measures would assist states in more accurate reporting and facilitate better benchmarking -- especially outside of managed care programs. States have little ability to compare utilization data, such as unnecessary emergency room visits, inpatient stays, or preventable emergency department visits, much less more clinically specific disease measures. Consistency in measure specification would also allow states to size themselves up against other states. "Someone has to do measure specification and maintenance of measures," noted an interviewee. As NQF considers how it strategically grows, the measure maintenance function could rest within NQF, as a spin-off of NQF, or within other measurement entities.

**5. *Medicaid's health reform priorities include the expansion population and delivery system innovations.***

Starting in 2014, an estimated 16 to 20 million Americans will be covered by the Medicaid program and another 16 million will be covered by state-based insurance exchanges. One of Medicaid's critical priorities related to health reform is to simplify eligibility and enrollment systems and connect them to the newly established exchanges. Another key priority for states is to better understand the expansion population, including their health status and health care needs. Early studies indicate the expansion population – primarily childless adults – will have substantial mental health and substance abuse needs.<sup>v</sup> Most interviewees noted this as an important measurement “gap” for NQF to fill.

States are also interested in taking advantage of delivery system innovations supported by the ACA, including medical homes and community health teams. States are eager to use these innovations to better manage the health of their sickest and costliest patients, but they also need measures that will allow them to determine the effectiveness of both the delivery system structure (e.g., staffing type and mix, patient-centeredness, teamwork, and efficiency) and clinical effectiveness (e.g., how do we construe attribution and accountability in a community health team with multiple providers and care settings?) of these models.

Other health reform innovations, including delivery system (i.e., accountable care organizations) and payment (i.e., bundled payment) redesign are not yet high priorities for Medicaid agencies. This is in part due to: (a) other high priority topics; (b) the technical and administrative infrastructure needed to support such efforts; and (c) state budget crises mandating short-term savings.

**6. *Engagement with Medicaid entities needs to be more meaningful.***

Medicaid stakeholders want clarity regarding NQF's role and functions in the quality measurement arena and how it differentiates itself from others. In addition, they want to be engaged via a more in-depth, cross-cutting mechanism.

Several interviewees had served on NQF-related advisory groups, but felt their participation was largely isolated from their day-to-day activities within Medicaid or had little bearing on the way their agency or Medicaid colleagues viewed and used NQF products. While many reported that they enjoyed working with NQF, they also noted that it was somewhat of an isolating experience.

“We’re like Star Trekkies landing on a new planet or something.” Several felt that they were invited for symbolic reasons, not for true engagement, which seemed restricted to the Medicare or commercial side of the table. One interviewee noted, “I’ve participated on NQF panels as a token Medicaid representative. There is little role for state perspective to be drawn in.” This was

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especially true for those representing population health or issues of vulnerable populations more broadly, “NQF has had blinders on regarding care delivered to poor people.”

Those who were familiar with NQF’s offering of 600+ measures noted that “NQF is called the National Quality *Forum*, not the national measurement factory.” NQF should do more in terms of convening, coalition-building, and framework-setting for states rather than simply endorsing measures. At the same time, interviewees welcomed the chance to work more intimately with NQF. “NQF has opportunity to help teach and move Medicaid along.”

“NQF is called the National Quality Forum, not the national measurement factory.”

## IV. Themes from Public Health Leaders

Dr. Don Berwick’s inclusion of “better health” as one of the Triple Aims of the Centers for Medicare & Medicaid Services (CMS) is welcomed by public health officials who recognize the need to focus on health and not just health care. However, interviewees noted that the most prevalent measure sets only include health care services linked to individual health outcomes, rather than behaviors and demographic factors that are reflections of the health of a community.

One official conjectured that even incremental improvements in tobacco and substance use might have a greater impact on population health than 100 percent improvement in current HbA1c testing levels, the latter of which also runs the risk of promoting system overuse.

Public health’s role includes tracking contributions to population health that are rarely considered by clinicians, including clean water, food safety, and access to recreation.

While public health officials aim to help individuals “eat better, move more, and be tobacco free,” interviewees felt the measurement world is “practice-oriented, focusing on clinical care processes and endpoints once the patient is already sick.”

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NQF could play a significant role in linking health and health care by determining critical population health objectives and how clinical care entities should be answerable to these goals. For example, should individual physicians or groups of physicians (e.g., an accountable care organization) be held accountable for the incidence of disease, the rate of smoking, or the number of obese people within their community? There is an opportunity for NQF to tackle these questions and support such paradigm shifts through the development of robust population health measures in the clinical care domain.

Interviewees also noted the importance of public health data systems as critical repositories for population health data. These data systems are further down the electronic highway, but are

not well-integrated with health care data in most states, let alone nationally. These systems are also largely underfunded. “The Feds have to stop siloed funding. We are trying to get 90/10 Medicaid administrative funding for a uniformed pediatric database (i.e., title V, registries, etc), but are told we have to cost allocate just for Medicaid.”

Public health leaders welcome convening forums where they can sit next to their clinical care colleagues in dialogue about measurement -- an experience they claim will be “an exercise in cross-cultural awareness.” Public health leaders would also value coalition-building by national entities such as NQF, so that national attention can be paid to successful local efforts (e.g., one official noted the success of New York City hospitals in requiring breastfeeding education prior to discharge) and, public health and Medicaid officials can learn from the best practices in leading-edge states and communities.

## V. Themes from Health Insurance Commissioners

State insurance commissioners face daunting new challenges in “right-setting” the insurance industry and using their newfound authority to regulate in more substantive ways. They are focused on the state-based exchanges and considering how the exchanges will be structured and governed. They are not yet focused on quality.

Although the exchanges are meant to be designed to promote competition on both price and *quality*, most interviewees noted that the timing is not yet ripe for a quality discussion. Too many states are focused on the structural issues of how the exchange will operate and how it will be governed. One interviewee noted: “Quality should be an issue in 2012 or 2013, but not now.” However, since the exchanges will create competitive markets with transparent quality information, these new vehicles could have a transformative effect on health care more broadly. The extent of this role will depend on whether the exchange looks more like a brokerage model vs. a proactive purchaser model. NQF could help states in driving the latter, but will want to approach states at a more ripe moment. All interviewees echoed loud and clear that “the exchange space is too amorphous right now to be thinking about measurement in productive ways.”

“Quality should be an issue in 2012 or 2013, but not now.”

State insurance commissioners, did however, note the rise of all-payer databases across the country and the ability to better capture utilization and expenditure information from such sources. Several interviewees noted the need for cost-efficient measures that could be captured across payers and be more reflective of a broader market.

## The State of State Capacity

State staff in both public health and Medicaid agencies described a gap between the need for resources related to quality, performance measurement, and information technology infrastructure and the current status of state budgets. State budgets are in dire straits and any discretionary funding at the state level (often used to fund public health infrastructure) is being cut, as much as 75 percent in one state interviewed. States are using early retirement, furloughs, hiring freezes, and travel freezes as ways to manage cost. One Medicaid director noted that “for all the health IT work that is coming down the pike, we have a staff of two.” The difficulties facing state budgets are an impediment to building a robust quality infrastructure at the state level.

In an attempt to prioritize limited resources for health information technology, some states are taking advantage of the ARRA meaningful use (MU) incentives. Several state staff report using MU measures to guide decision-making about building the capacity needed to collect and report quality

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measures. The CHIPRA and adult core measures will need to reflect MU standards as well. Medicaid staff recommend that NQF take note of the MU requirements and timeline in rolling out their “e-measures.” States also caution NQF and other entities looking to “pile on” new electronically-based quality tools against pulling a “bait and switch” on providers, which they fear might happen if Stage 2 and Stage 3 of meaningful use rules become cumulatively burdensome.

Noting that electronic health records (EHRs) will not be fully operable in the near future, some interviewees suggest that NQF should think about how measures can be based on other sources such as pharmacy claims, lab data, and chart reviews, in the shorter term. However, for data from such disparate sources to be turned into meaningful information, state agencies would need to link data sets, and the capacity for that work is strained due to the same budget limitations described above. A major challenge in the creation of effective linkage between systems is the role of patient identifiers in tracking patients across various providers and within multiple state agencies. The basic infrastructure for managing existing data sets was described as “crumbling” by one interviewee, and the staff to take on new linkage work does not exist.

The future challenges must be considered, however tight the resources for planning. States are beginning to grapple with the prospect of the interoperability of EHRs and the health information exchange with legacy Medicaid Management Information Systems (MMIS). States are hoping that future measurement will be more robust if they can manage the smooth transition from reliance on administrative and claims-based data to clinical data.

## VI. Recommendations for NQF

The following recommendations for NQF are based on the insights and themes above and provide specific suggestions on how NQF can respond to the changing state health care landscape. States are eager to have a growing and more meaningful role with NQF, but such a partnership will require a new perspective and new funding models.

As NQF repositions itself to respond to health reform, and specifically the expanding health coverage role of states, it should consider the following:

**1. Develop a measurement endorsement agenda that includes both populations and services that are more reflective of state-based programs.**

NQF could help champion “low-income issues.” “It’s like 1962 in poor America. Let’s think about childhood caries the way we thought about tuberculosis. Let’s think about tobacco the way we thought about cholera. We turn a blind eye to low-income issues.” NQF could help raise the importance of these challenges at a national level.

**2. Develop a state-level strategic quality measurement dashboard that reflects the health care system in total as opposed to individual components of the health care system.**

NQF could develop a *Medicaid Community Dashboard* to provide a strategic framework for states that cuts across primary, specialty, behavioral, and long-term care services. The dashboard would include a parsimonious set of measures that “measure system performance, not just narrow disease stuff” and would embrace “simplicity as a driving factor.” The dashboard could include “core” measures from the current community dashboard that NQF is developing, but should also include measures more specific for the Medicaid population.

**3. Bridge the health care system and public health by identifying population-based measures for which the health care system can be held accountable.**

The linkage between health and health care is a blue ocean and NQF could chart the course given its reputation and standing. Incorporating a measurement framework that addresses both clinical and population health endpoints into the *Medicaid Community Dashboard* could be a starting point for building long-term infrastructural bridges at the state level.

**4. Convene a focused, strategic working group of states to help build the quality measurement dashboard.**

NQF should establish a workgroup of state officials cutting across Medicaid, public health, and insurance to assist in building the *Medicaid Community Dashboard*. The workgroup should have a clear charge, convene multiple times, and include numerous state officials.

**5. Function as a national bully-pulpit to advance a value-driven purchasing agenda for state purchasers. Hold states publicly accountable for their use of an NQF Medicaid Community Dashboard.**

Beyond just developing the *Medicaid Community Dashboard*, NQF could actually hold states accountable for publicly reporting results. NQF could use its national “imprimatur” to develop a “state scorecard” on whether states are using and publicly reporting on the dashboard. As one interviewee noted, “NQF is playing it safe. They need to go out on a limb more and create the momentum to focus on value and hold states accountable.”

**6. Determine whether NQF should maintain measure specifications or “spin off” an organization responsible for developing and maintaining measure specifications.**

To meet the needs of states, NQF will need to devote additional resources toward measure specification or decide whether those resources are best used in other strategic areas. NQF could also help establish a “spin-off” organization with this as a sole focus, or rely on other national measurement entities to perform this function.

**7. Build an organization receptive to state needs, which may necessitate new models of funding and staffing and an organizational culture that looks outside the beltway.**

“Organizations inside the beltway often think the best ideas will rise from the top,” noted one interviewee, rather than working from the get-go with local and state policymakers to discover and promote successful practices that could resonate across multiple levels of governance. With this in mind, a state or regional-based organizational strategy would necessitate new resources, new staff, and a new culture that is receptive to the different needs of 50 states. NQF may need to evaluate its internal priorities and structure as it considers how to be more hands-on as well as more bottom-up.

**8. Develop targeted information for states about NQF’s mission, its functions and programs; how it differentiates itself from other measurement bodies such as NCQA; and how it coordinates with agencies within the Department of Health and Human Services, specifically AHRQ and CMS.**

NQF should proactively communicate with states more regularly and with targeted messages. It can better distinguish itself and its products, but also highlight how it is working with federal governmental entities.

**9. Recognize that working with states necessitates a new funding model.**

States are cash poor. NQF will not be able to build bridges with states if it relies solely on its membership model to do so. NQF should provide free membership and travel for meetings or conferences for states. More importantly, NQF should seek additional funding sources (i.e. federal funding or philanthropic funding) to support state-level work.



**10. Don't wait for states to join you. Cultivate an aggressive outreach campaign to Medicaid, public health, and insurance department officials.**

NQF can connect with multiple trade associations that represent state officials, including the National Associate of Medicaid Directors (NAMd), the Association of State and Territorial Health Officials (ASTHO), and the National Association of Insurance Commissioners (NAIC). Notably, one insurance commissioner interviewed enthusiastically offered to invite NQF to speak at the next NAIC meeting. More time and effort should also be spent cultivating relationships with cutting-edge quality measurement states, e.g., Minnesota, New York, and Pennsylvania, who can promote and advance NQF's work. To cultivate relationships, NQF should call every new state health commissioner or state Medicaid director and say, "we're here." The organization should keep a list-serve, constantly talk to states, and connect with the quality staff.

## Appendix A: List of Key Informants

Interviews conducted by Center for Health Care Strategies (CHCS)  
 Interview Period: November 1, 2010 – January 15, 2011

Type	No.	Key Informants
Medicaid Director	3	<ul style="list-style-type: none"> <li>• Susan Besio, Vermont (spoke with Medical Director, Michael Farber and Director of Managed Care, Vickie Loner)</li> <li>• Judy Mohr-Peterson, Oregon</li> <li>• Sandeep Wadhwa, 3M Corporation (former Medicaid director, Colorado)</li> </ul>
Medicaid Medical Director	5	<ul style="list-style-type: none"> <li>• Foster Gesten, New York</li> <li>• David Kelley, Pennsylvania</li> <li>• Jeff Schiff, Minnesota</li> <li>• Bill Golden, Arkansas</li> <li>• Doris Lotz, New Hampshire</li> </ul>
Executives / Chief Medical Officers of Medicaid Health Plans	3	<ul style="list-style-type: none"> <li>• David Labby, Care Oregon</li> <li>• Colleen Kivlahan, Schaller Anderson of Aetna</li> <li>• Lewis Sandy, United Healthcare</li> </ul>
Health Department Officials	4	<ul style="list-style-type: none"> <li>• Lynn Mitchell, Oklahoma (former Medicaid Director)</li> <li>• Heather Howard, New Jersey (former Health Commissioner)</li> <li>• Maxine Hayes, Washington</li> <li>• Paul Jarris, Association for State and Territorial Health Officials</li> </ul>
Health Insurance Commissioners/Officials	3	<ul style="list-style-type: none"> <li>• Chris Koller, Rhode Island</li> <li>• Sandy Praeger, Kansas</li> <li>•</li> </ul>
Provider and Public Health Perspective	2	<ul style="list-style-type: none"> <li>• David Stevens, National Association of Community Health Centers</li> <li>• Bruce Siegel, National Association of Public Hospitals</li> </ul>
Others	3	<ul style="list-style-type: none"> <li>• Kyu Rhee, Health Resources and Services Administration (HRSA)</li> <li>• Lee Partridge, National Partnership for Women and Families</li> <li>• Joel Weissman, Assoc. Professor at Morgan Institute for Health Policy, Mass. Gen. Hospital/Harvard Med School</li> <li>• Trish Riley, Maine</li> </ul>

## *Appendix B: Interview Protocol*

### *Background:*

As the Patient Protection and Affordable Care Act (ACA) positions states to assume even greater responsibility in purchasing health care via Medicaid expansions and state-based insurance exchanges, and promoting individual and community health, ongoing activities to measure and improve health and health care quality at the state level are essential. In particular, given its sheer size and its continuing transformation from a bill payer to an active health care purchaser, Medicaid can play an important role in advancing the use of nationally-endorsed performance measures.

The National Quality Forum (NQF), a national organization committed to measurement endorsement, consensus-building, and priority-setting, recognizes the fundamental role of States in the implementation of health care reform and is interested in working with State leaders to promote further adoption of nationally-endorsed measures for use with Medicaid and across the population as a whole. In particular, the NQF seeks to:

- Create greater alignment - through two-way feedback and learning - between the goals of Medicaid programs and State population health aims, and the work of NQF's National Priorities Partnership (NPP) and national measurement endorsement agenda, with attention to the identification of critical gaps in existing measures;
- Incorporate State priorities for addressing the needs of vulnerable populations into the formal consensus development process used by NQF when evaluating and endorsing measures; and
- Produce materials and tools that are valuable to States in their work to measure and improve population health and health care.

To achieve these goals, the NQF has contracted with Center for Health Care Strategies (CHCS) to document the unique populations served by States as well as State measurement priorities, requirements, and infrastructure capacity. CHCS will conduct interviews with Medicaid leadership and State public and population health stakeholders and report findings to NQF in early 2011.

*Interview Questions:*

**Measurement priorities:**

(Please see background document for information on NQF and its programs)

- 1) Are you familiar with NQF? If so, how would you describe the focus of NQF and its products and services? Is your organization a member of NQF? Has your organization participated in any NQF projects? If not, why not?
- 2) Do you currently use any NQF- endorsed measures? Are there gap areas in which you would like to see more measures? Are there any particular measurement domains especially salient to your organization from a cost, quality, and/or disparities context?
- 3) Are there prevention, health promotion, and/or public health issues that you would like NQF to think more about? What challenges and opportunities do you see for a State to link population health measures to ongoing measurement activities at the health plan, hospital, and provider level within Medicaid?
- 4) How have your organization's priorities changed, if at all, with the passage of national health reform and/or the current economic climate?
- 5) Given your organization's priorities, are there any educational tools and topics, convening opportunities, or other technical assistance that you would find valuable from a national quality/measurement organization like NQF?

**Measurement Tools and Infrastructure Capacity:**

- 1) What kinds of performance measurement tools do you use at the following levels: a) State (e.g., immunization records, registries); b) Health plan (e.g., HEDIS, NBCH eValue8); c) Provider (e.g., hospital/ambulatory care clinical metrics); and d) Consumer (e.g., CAHPS, satisfaction surveys).
- 2) What should NQF know about the challenges in gathering data from various State agency sources (e.g., Medicaid, mental health, public health, child welfare, social services) for measurement? What insight can you give to NQF on the challenges of using non-claims data (e.g., pharmacy, lab, clinical, consumer survey, registries) for measurement?
- 3) NQF is working on a method for the development of "e-measures" for which data can be derived from electronic health records (EHRs). Where is your organization positioned in terms of developing EHRs, meeting Meaningful Use criteria and/or participating in the Health Information Exchange? How have ARRA requirements and other health information technology considerations impacted your quality measurement strategy?

- 4) Has your organization considered how quality measurement will apply in the State-based insurance exchange? What are potential barriers to this that you would like NQF to be aware of?
- 5) How is your organization preparing for the Medicaid expansion population in 2014? Are there particular clinical domains for this population (e.g. mental health, substance abuse) or infrastructure capacity and measurement issues that will become more salient as a result of states' expanded roles as purchasers, that you think NQF should pay attention to?

**Federal Initiatives:**

- 1) How is your organization planning to address the growing list of national requirements for measurement, public reporting and/or payment reform, such as:
  - Children's Health Insurance Program Reauthorization Act (CHIPRA) child measures;
  - ACA adult measures;
  - Meaningful use for Health Information Technology (HIT); and/or
  - ACA-mandated race/ethnicity/language collection for federally-supported programs.
- 2) What kind support or services would you find valuable from NQF regarding these multiple federal initiatives?
- 3) NQF has responded to the Health and Human Services (HHS)'s request for public comment for the ACA-mandated national quality strategy (see NPP information in background document) and will provide input into the national prevention strategy as well. What quality and prevention issues salient to your organization should CHCS share with NQF?

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<sup>i</sup> National Public Radio, "Pawlenty Touts Minnesota's Lessons On Health Care," January 11, 2011. Available at: <http://www.npr.org/2011/01/11/132815702/pawlenty-touts-minnesotas-lessons-on-health-care>

ii E. McNichol, P. Oliff and N. Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, December 16, 2010.

iii J. Holahan and I. Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2010

iv County Health Rankings model © 2010 University of Wisconsin Population Health Institute

v S. Somers, A. Hamblin, J. Verdier and V. Byrd. "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States." Center for Health Care Strategies. August 2010