Establishment of a Partnership for Applying Measures to Improve Quality

to Provide Input on Measure Selection for Public Reporting and Payment Programs

Introduction

The Patient Protection and Affordable Care Act (PPACA) establishes new requirements for the Secretary of Health and Human Services to seek multi-stakeholder input on measures and assigns new duties to the consensus-based entity.[1] Among those new duties, the entity is required to convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures for public reporting and payment programs for use by CMS and potentially other Federal agencies.[2] The multi-stakeholder groups, not the consensus-based entity, are charged with making recommendations to the Secretary. The Secretary retains the authority to make final determinations on the selection of measures for public reporting and payment programs, after considering input from other stakeholders through the regular rulemaking process.[3]

NQF, which currently serves as a consensus-based entity under contract with HHS, may be tasked with carrying out this consultative process in its role as neutral convener. To prepare for that potential new responsibility, this paper proposes that the NQF Board establish a new Consultative Partnership, named here the "Partnership for Applying Measures to Improve Quality."

In anticipation of the potential need for such a Consultative Partnership, the NQF Board, at its December 2009 meeting, discussed key policy and operational issues for a Partnership, including objectives, membership, transparency, products, and the need to seek broader input, particularly from existing alliances. An NQF Board work group met January-April 2010 to consider the charge and structure for a potential Partnership for Applying Measures to Improve Quality.

Using the groundbreaking work of the current quality alliances as a foundation, the Board work group developed a range of options to respond to the law and build on the work begun by the quality alliances, assuming the addition of robust analytical capability enabled by an infusion of Federal funding. Recognizing the importance of broad stakeholder input, the Board work group first sought reaction from the AQA Alliance (AQA), the Hospital Quality Alliance (HQA), and the Pharmacy Quality Alliance (PQA), with the ultimate intention of wide-ranging vetting. The results of these interactions are reflected here.

Activities of a Partnership for Applying Measures to Improve Quality

The PPACA assigns the consensus-based entity responsibility for convening multi-stakeholder groups to provide input to the Secretary on the selection of quality measures for public reporting and payment programs.[4] Public reporting and payment programs are construed expansively for this purpose to cover a range of Medicare payment programs, HHS public reporting programs, and other unspecified health

[1] See HR 3590 §§3011 and 3013-15.
[2] HR 3950 §3014, amending Social Security Act §1890(b) by adding (7)-(8), and by adding §1890A.
[3] Ibid.
[4] HR 3590 §3014.

care programs.[5] "Multi-stakeholder group" is defined in statute as a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of quality measures.[6]

Some elements of the process for providing the multi-stakeholder input are also defined in statute, and the Secretary will have the discretion to use the multi-stakeholder input more broadly. Not later than December 1 of each year, beginning with 2011, HHS must make available to the public a list of measures that are being considered.[7] Not later than February 1 of each year, beginning with 2012, the entity must transmit the pre-rulemaking input of the multi-stakeholder groups to HHS.[8]

In the near term, key activities of the Partnership for Applying Measures to Improve Quality would include providing pre-rulemaking input on the selection of measures for the Reporting Hospital Quality Data for the Annual Payment Update program (also referred to as RHQDAPU, Hospital Compare, and the hospital pay-for-reporting program) and the Physician Quality Reporting Initiative (also referred to as PQRI and the physician pay-for-reporting program). In the longer term, the Partnership could provide input on new programs like the hospital readmissions reduction program, which begins in fiscal year 2013,[9] and the payment adjustment for conditions acquired in hospitals, which begins in fiscal year 2015.[10] The Partnership could also have input into the selection of measures for emerging programs and demonstrations that are driving away from siloed payment systems toward clinical integration. Some examples of promising payment reforms with stepping stones defined in statute as Medicare demonstrations or pilot programs are medical homes,[11] accountable care organizations,[12] and bundled payment approaches.[13]

In addition to these current and new payment programs, HHS is directed under the statute to publicly report performance information through standardized websites.[14] The information must be tailored to respond to the different needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders.[15] HHS must ensure that the collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.[16] Specifically, HHS must establish a Physician Compare website by January 1, 2011.[17] The Partnership for Applying Measures to Improve Quality would provide input into the selection of measures for these HHS public reporting websites.[18]

[5] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(B)(i)(I)-(III).
[6] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(D).
[7] HR 3590 §3014(b), amending SSA §1890A by adding (a)(2).
[8] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (8) and by adding §1890A(a)(3).
[9] HR 3590 §3025(a), amending SSA §1886 by adding (q)(1).
[10] HR 3590 §3008(a), amending SSA §1866 by adding (p)(1).
[11] See, e.g., HR 3590 §§2703, 3021, and 3502.
[12] See, e.g., HR 3590 §§2706 and 3022.
[13] See, e.g., HR 3590 §§2704 and 3023.
[14] HR 3590 §3015, amending PHSA §399 by adding JJ(a).
[15] Ibid.
[16] HR 3590 §3015, amending PHSA §399 by adding II(a).
[17] HR 3590 §10331(a)(1).
[18] HR 3590 §3015, amending PHSA §399 by adding JJ(c)(1)-(2).

Key Considerations in the Establishment of a Partnership for Applying Measures to Improve Quality

Involvement of stakeholder groups

The Partnership for Applying Measures to Improve Quality is meant to meet the requirements of the PPACA and build on the commitment of many stakeholders to the important work of the current quality alliances. The fact that the PPACA provides for a consultative function around the selection of measures is recognition of the valuable contributions that quality alliances have made in this area. The new Partnership structure must be capable of making measure recommendations across a broad set of public reporting and payment programs, and must comply with legislative requirements pertaining to transparency and due process, but it should also build on the successes of the alliances in this area. With a strong mandate and greater financial resources available to the Partnership, there is also the opportunity to provide stronger analysis for decision-making to support the multi-stakeholder input.

Careful coordination between the ongoing activities of the quality alliances and the new activities of the Partnership for Applying Measures to Improve Quality will be necessary to avoid duplication of effort by the volunteer members of the alliances and the Partnership. The current quality alliances will be key contacts for input and a focus for engagement as the Partnership is being established and begins operations. The alliances will be solicited for nominations of members to serve on the Partnership and for comment on the selected members and comment on recommendations to HHS.

The Federal agencies that are involved in the development and use of quality measures are obviously important stakeholders. Though Federal officials are not typically voting members of groups that make recommendations to the Federal government, the Partnership would benefit greatly from having identified liaisons from the relevant agencies.

Transparency and due process

The PPACA requires that the consultative process for convening multi-stakeholder groups be open and transparent in its initial construction and ongoing operations.[19] Public nominations must be sought for members of the multi-stakeholder groups, and public comment must be sought on member selection.[20] According to NQF policy, nominees for membership will be required to disclose conflicts of interest.

The Partnership for Applying Measures to Improve Quality will operate in a transparent manner. Meetings will be publicly announced and convened in open session, unless specific matters require an executive session. Summaries of deliberations will be publicly available in a timely manner. Public comment will be sought on recommendations, including written comments and verbal comments during meetings.

Analytic support for evidence-based decision making

Federal funding under PPACA will likely be adequate to support some analytic activities. The Partnership for Applying Measures to Improve Quality's multi-stakeholder input should be supported by the best available evidence and analysis. Strong analytical capability will be needed to support Partnership decision making in this fast moving environment. NQF staff will respond to the analytic

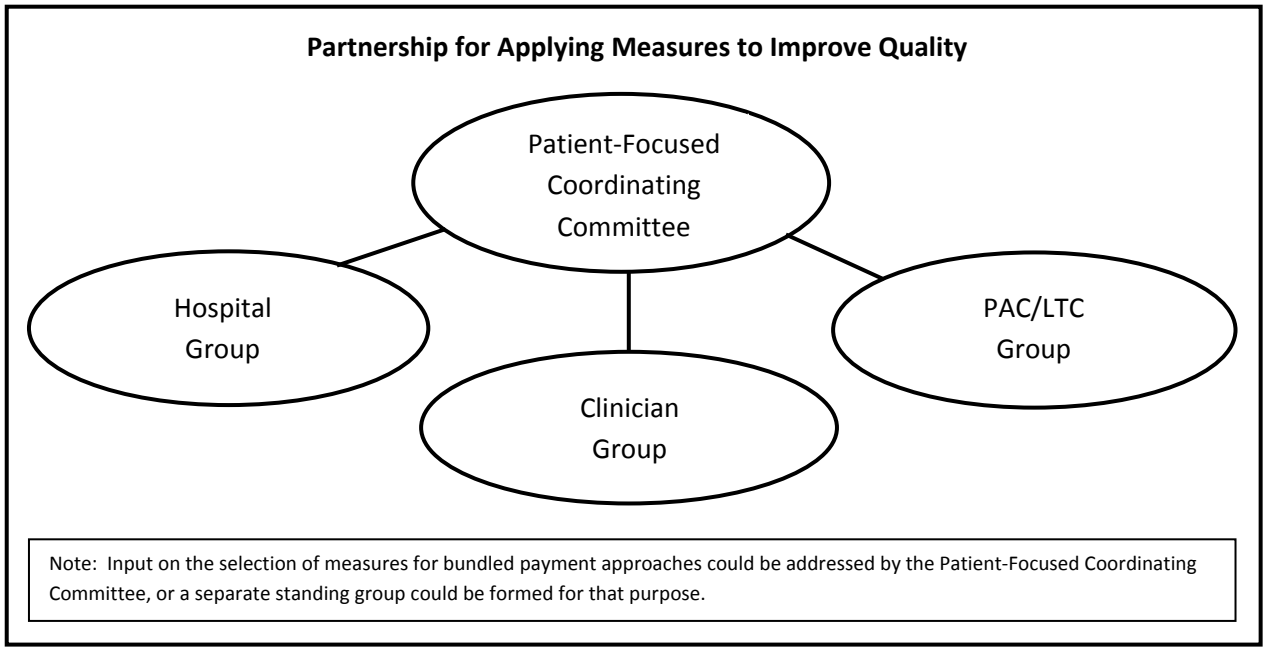
[19] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(C)(i).
[20] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(C)(ii).

needs that are identified by the Partnership. For research questions that cannot be answered by evidence available to NQF staff or by subject matter expert members of the Partnership groups, NQF will subcontract with health services research entities for analysis to support decision making.

In-depth analysis will be needed for some issues, while quick turnaround will be needed for others. Three relevant examples of illustrative of processes that provide evidence to support recommendations are discussed in an appendix to this paper. The examples are: (1) an in-depth NQF-RAND project that is currently underway, (2) the ECRI Institute's approach to providing analytical support for technology planning and assessment, and (3) the quick turnaround approach to policy analysis used by the California Health Benefits Review Program. These examples are intended to be illustrative only. In identifying subcontractors, NQF will follow appropriate Federal subcontracting requirements and ensure that the process is open to all types of organizations.

Flexible structure

Initial feedback from the quality alliances about the structure of the Partnership for Applying Measures to Improve Quality indicated preference for a two-tiered approach: (1) a central, multi-stakeholder coordinating group, named here the "Patient-Focused Coordinating Committee," and (2) multi-stakeholder work groups addressing measures for specific care providers like hospitals and clinicians. This structure would be sensitive to the needs of the provider constituencies represented by the current quality alliances, while still providing a strong, unified voice.



The Patient-Focused Coordinating Committee would play a strategic role by focusing on the measures needed for public reporting and payment approaches that cut across individual clinicians and provider sites of care. For example, the Coordinating Committee would consider issues related to the alignment of measures and promotion of shared accountability and care coordination among provider types. In addition to stakeholder representatives, the Coordinating Committee would need members with subject matter expertise in measurement, public reporting to support informed decision making, and performance-based payment approaches. The provider-focused work groups would perform the

narrower utility function of providing immediate input on the selection of measures for current public reporting and payment programs like RHQDAPU and PQRI. The recommendations of the work groups would flow through the Coordinating Committee to HHS to avoid conflicts and diffusion of the voice of the Partnership.

The structure and function of the Partnership for Applying Measures to Improve Quality would be evaluated periodically and would evolve based on the evaluation results. Based on these findings and lessons learned, the Partnership structure would be continually assessed to assure that it is that is patient-focused, efficient to administer, building on prior work, and making efficient use of volunteer members' time.

Relationship between the Partnership for Applying Measures to Improve Quality and the NQF Board

The PPACA calls for the consensus-based entity to convene multi-stakeholder groups to provide input to the Secretary on the selection of measures for public reporting and payment programs. Thus, if NQF is selected as the consensus-based entity, the NQF Board will be responsible for establishing the convening structure and ensuring the integrity of the convening process. The Board's responsibilities will include appointment of the multi-stakeholder members of the Partnership for Applying Measures to Improve Quality and periodic evaluation of the Partnership's structure and processes.

The Partnership for Applying Measures to Improve Quality will regularly report on progress to the NQF Board. A comprehensive assessment of the Partnership's function will be completed annually, and a thorough impact evaluation will be conducted by an independent third party every three years.

The consensus-based entity itself is not charged with making recommendations to the Secretary, so the Partnership for Applying Measures to Improve Quality's substantive recommendations will not flow through the NQF Board for ratification or approval. However, a mechanism for the NQF Board to address issues raised about the Partnership's processes will need to be established.

Appendix
Examples of Processes that Provide Evidence to Support Recommendations

RAND Measurement Implications of Performance-Based Payment Reform Models

NQF has engaged Eric Schneider at RAND to serve as the principal investigator for a two-part project to catalog existing performance-based payment reform models and then to analyze the measurement implications for these new payment approaches. RAND has identified nearly 80 models for the catalog from Federal (i.e., reform legislation, Medicare programs and demonstrations, and MedPAC recommendations), State, and private sector sources. The models will be classified according to typical approaches to performance-based payment (e.g., pay for performance, bundling, global payment, hospital-physician gainsharing, accountable care organizations, medical homes). Each performance-based payment approach will be analyzed for measure needs, methodological measurement issues raised (e.g., attribution, risk adjustment, sample size, data source), and measure gaps. This in-depth analysis will support decision making about measure sets for each approach, as well as measurement implementation issues that need to be overcome and measure gaps that need to be filled.

ECRI Technology Planning and Assessment

The ECRI Institute is a nonprofit organization that performs applied scientific research to determine which medical procedures, devices, drugs, and processes lead to the best outcomes in patient care.[21] ECRI provides clients with evidence-based research, testing, investigations, information, planning, and advice. ECRI's Health Technology Assessment Information Service evaluates healthcare technologies and services along the continuum of evidence from research and development to maturity, to guide coverage and implementation decisions. Their clients receive reports from systematic evidence reviews and trend analysis, and can also submit custom requests for information and for quick consultations tailored to address a particular need. ECRI's multidisciplinary staff includes doctoral-level scientists, clinicians, technologists, medical librarians, and other healthcare professionals.

California Health Benefits Review Program (CHBRP)

The California Legislature established the CHBRP at the University of California to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefits mandates and repeals.[22] The CHBRP's small analytic staff leverages faculty from universities across the State, as well as actuarial consultants (CHBRP has contracted with Milliman) and a National Advisory Council. CHBRP produces quick turnaround reports within a strict 60-day production period. The reports summarize the evidence relevant to a proposed mandate, but CHBRP does not make recommendations in deference to State policymakers.

NOTE: These examples are intended to be illustrative only. In identifying subcontractors, NQF will follow appropriate Federal subcontracting requirements and ensure that the process is open to all types of organizations.

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[21] ECRI Institute website, available at: https://www.ecri.org/Products/TechnologyPlanningAssessment/Pages/default.aspx, accessed March 30, 2010.
[22] California Health Benefits Review website, available at: http://chbrp.org/, accessed March 30, 2010.