NQF
National Quality Forum

Measure Applications Partnership Workgroup Orientation

Web Meeting

May 13, 2011
2:00 pm – 4:00 pm ET

Webinar access: http://www.MyEventPartner.com/QualityForum8

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Coordinating Committee Roster

Tab 1

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Coordinating Committee

Co-Chairs (voting)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

Organizational Members (voting)	Representatives
AARP	Joyce Dubow, MUP
Consumers Union	Steven Findlay, MPH
National Partnership for Women and Families	Christine Bechtel, MA
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Pacific Business Group on Health	William Kramer, MBA
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
Academy of Managed Care Pharmacy	Judith Cahill
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Medical Association	Carl Sirio, MD
American Nurses Association	Marla Weston, PhD, RN
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
Federation of American Hospitals	Charles Kahn III
American Medical Group Association	Sam Lin, MD, PhD, MBA
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
AdvaMed	Michael Mussallem

Expertise	Individual Subject Matter Expert Members (voting)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Karen Milgate, MPP
Health Resources and Services Administration (HRSA)	Victor Freeman, MD, MPP
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Thomas Tsang, MD, MPH

Accreditation/Certification Liaisons (non-voting)	Representatives
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Margaret O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Coordinating Committee Charge

Tab 2

Measure Applications Partnership
Coordinating Committee Charge

Purpose

The charge of the Measure Applications Partnership (MAP) Coordinating Committee is to provide input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs. The Coordinating Committee will also advise HHS on the coordination of performance measurement strategies across public sector programs, across settings of care, and across public and private payers.

The Coordinating Committee will set the strategy for the two-tiered Partnership and give direction to, and ensure alignment among, the MAP advisory workgroups. The workgroups will not give input directly to HHS; rather, they will advise the Coordinating Committee on measures needed for specific uses.

The work of the Coordinating Committee and input to HHS will be aligned with the HHS National Quality Strategy, as well as the related National Prevention and Health Promotion Strategy and National Patient Safety Initiative. The Committee's decision making framework will also consider high priority conditions and the patient-focused episode of care model. The Committee will adopt a set of measure selection criteria to guide its decisions. Explicit consideration will be given to performance measures needed for dual eligible beneficiaries in all of the MAP's work.

The activities and deliverables of the MAP Coordinating Committee do not fall under NQF's formal consensus development process (CDP).

Tasks

The Coordinating Committee will set the strategy for the MAP; give direction to the advisory workgroups; ensure alignment of performance measurement across settings; and provide input to HHS through the following tasks:

1. Set a decision making framework, including measure selection criteria.
2. Identify charges for each workgroup.
3. Provide input to HHS on:
    a. Measures to be implemented through the federal rulemaking process, based on an overview of the quality problems in hospital, clinician office, and post-acute/long-term care settings, the manner in which those problems could be improved, and the related measures for encouraging improvement;
    b. A coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers;
    c. A coordination strategy for clinician performance measurement across public programs;

   d. Identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries;
   e. A coordination strategy for performance measurement across post-acute care and long-term care programs;
   f. Identification of measures for use in performance measurement for hospice programs and facilities; and
   g. Identification of measures for use in performance measurement for PPS-exempt cancer hospitals.
4. Identification of critical measure development and endorsement gaps.

Timeframe

The first phase of this work will begin in March 2011 and will be completed by June 2012.

Membership

Attachment A contains the MAP Coordinating Committee roster.

The terms for MAP members are for three years. The initial members will serve staggered terms, determined by random draw at the first in-person meeting.

Procedures

Attachment B contains the MAP member responsibilities and operating procedures.

MAP Workgroups Roster

Tab 3

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)
Roster for the MAP Clinician Workgroup

Chair (voting)
Mark McClellan, MD, PhD

Organizational Members (voting)	
American Academy of Family Physicians	Bruce Bagley, MD
American Academy of Nurse Practitioners	Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP
American Academy of Orthopaedic Surgeons	Douglas Burton, MD
American College of Cardiology	Frederick Masoudi, MD, MSPH
American College of Radiology	David Seidenwurm, MD
American Speech-Language-Hearing Association	Janet Brown, MA, CCC-SLP
Association of American Medical Colleges	Joanne Conroy, MD
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	Dick Salmon, MD, PhD
Consumers' CHECKBOOK	Robert Krughoff, JD
Unite Here Health	Elizabeth Gilbertson, MS
Kaiser Permanente	Amy Compton-Phillips, MD
Minnesota Community Measurement	Beth Averbeck, MD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars, MSSW

Expertise	Individual Subject Matter Expert Members (voting)
Disparities	Marshall Chin, MD, MPH, FACP
Shared Decision Making	Karen Sepucha, PhD
Population Health	Eugene Nelson, MPH, DSc
Team-Based Care	Ronald Stock, MD, MA
Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP
Measure Methodologist	Dolores Yanagihara, MPH

Federal Government Members (non-voting, ex officio)	
Agency for Healthcare Research and Quality (AHRQ)	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Michael Rapp, MD, JD, FACEP
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of the National Coordinator for HIT (ONC)	Thomas Tsang, MD, MPH
Veterans Health Administration (VHA)	Joseph Francis, MD, MPH

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George J. Isham, MD, MS

Elizabeth A. McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Dual Eligible Beneficiaries Workgroup

Chair (voting)
Alice Lind, MPH, BSN

Organizational Members (voting)	Representative
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana	Thomas James, III, MD
LA Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD

Expertise	Individual Subject Matter Expert Members (voting)
Substance Abuse	Mady Chalk, MSW, PhD
Emergency Medical Services	James Dunford, MD
Disability	Lawrence Gottlieb, MD, MPP
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members (non-voting, ex officio)	Representative
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Health Care Office	Cheryl Powell
Health Resources and Services Administration	Samantha Wallack, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
Veterans Health Administration	Daniel Kivlahan, PhD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the Hospital Workgroup

Chair (voting)
Frank G. Opelka, MD, FACS

Organizational Members (voting)	Representatives
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Kasey Thompson, PharmD
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

Expertise	Individual Subject Matter Expert Members (voting)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Pamela Cipriano, PhD, RN NEA-BC, FAAN
Veterans Health Administration (VHA)	Michael Kelley, MD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Post-Acute Care/Long-Term Care Workgroup

Chair (voting)

Carol Raphael, MPA

Organizational Members (voting)	Representative
Aetna	Randall Krakauer, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder, PT
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
Family Caregiver Alliance	Kathleen Kelly, MPA
HealthInsight	Juliana Preston, MPA
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Hospice and Palliative Care Organization	Carol Spence, PhD, RN
National Transitions of Care Coalition	James Lett II, MD, CMD
Providence Health and Services	Robert Hellrigel
Service Employees International Union	Charissa Raynor
Visiting Nurse Associations of America	Emilie Deady, RN, MSN, MGA

Expertise	Individual Subject Matter Expert Members (voting)
Clinician/Nursing	Charlene Harrington, PhD, RN, FAAN
Care Coordination	Gerri Lamb, PhD, RN, FAAN
Clinician/Geriatrics	Bruce Leff, MD
State Medicaid	MaryAnne Lindeblad, MPH
Measure Methodologist	Debra Saliba, MD, MPH
Health IT	Thomas von Sternberg, MD

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)	Judy Sangl, ScD
Centers for Medicare & Medicaid Services (CMS)	Shari Ling, MD
Veterans Health Administration (VHA)	Scott Shreve, MD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George Isham, MD, MS

Elizabeth McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Ad Hoc Safety Workgroup

Chair (voting)
Frank G. Opelka, MD, FACS

Organizational Members (voting)	Representatives
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Kasey Thompson, PharmD
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MSHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

Expertise	Individual Subject Matter Expert Members (voting)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	John Bott, MSSW, MBA
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Pamela Cipriano, PhD, RN NEA-BC, FAAN

Veterans Health Administration (VHA)	Michael Kelley, MD
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of Personnel Management/FEHBP (OPM)	John O'Brien

Payers (voting)	**Representatives**
Aetna	Randall Krakauer, MD
America's Health Insurance Plans	Aparna Higgins, MA
CIGNA	Dick Salmon, MD, PhD
Humana	Thomas James III, MD
LA Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Medicaid Directors	Foster Gesten, MD

Purchasers (voting)	**Representatives**
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Unite Here Health	Elizabeth Gilbertson, MS
Pacific Business Group on Health	William Kramer, MBA
The Alliance	Cheryl DeMars, MSSW

Expertise	**Individual Subject Matter Expert Members (voting)**
Payer	Lawrence Gottlieb, MD, MPP, FACP
Payer	Rhonda Robinson Beale, MD
Payer	MaryAnne Lindeblad, BSN, MPH

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

MAP Schedule of Deliverables

Tab 4

Measure Applications Partnership - Schedule of Deliverables

Task	Task Description	Deliverable	Timeline
15.1: Measures to be implemented through the Federal rulemaking process	Provide input to HHS on measures to be implemented through the Federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the measures for encouraging improvement.	Final report containing the Coordinating Committee framework for decision making and proposed measures for specific programs	Draft Report: January 2012 Final Report: February 1, 2012
15.2a: Measures for use in the improvement of clinician performance	Provide input to HHS on a coordination strategy for clinician performance measurement across public programs.	Final report containing Coordinating Committee input	Draft Report: September 2011 Final Report: October 1, 2011
15.2b: Measures for use in quality reporting for post-acute and long term care programs	Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	Draft Report: January 2012 Final Report: February 1, 2012
15.2c: Measures for use in quality reporting for PPS-exempt Cancer Hospitals	Provide input to HHS on the identification of measures for use in performance measurement for PPS-exempt cancer hospitals.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.2d: Measures for use in quality reporting for hospice care	Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.3: Measures that address the quality issues identified for dual eligible beneficiaries	Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report from the Coordinating Committee containing a performance measurement framework for dual eligible beneficiaries	Draft Interim Report: September 2011 Final Interim Report: October 1, 2011
		Final report from the Coordinating Committee containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	Draft Report: May 2012 Final Report: June 1, 2012
15.4: Measures to be used by public and private payers to reduce readmissions and healthcare-acquired conditions	Provide input to HHS on a coordination strategy for readmission and HAC measurement across public and private payers.	Final report containing Coordinating Committee input regarding a strategy for coordinating readmission and HAC measurement across payers	Draft Report: September 2011 Final Report: October 1, 2011

Draft MAP Timeline

Tab 5

HHS Task 15 - Timeline by Group -- REVISED May 10

DRAFT

Group	2011									2012					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	**April 8 10a-12p** - 2 hr web meeting	**May 3 -4** - 2 day in-person meeting: big picture planning, charge for workgroups, framework (**May 13 2-4p** - 2 hr ALL MAP optional attendance at group web meeting)	**June 21-22** - 2 day in-person meeting, clinician- coordination strategy, dual's interim report, framework	**Aug 5 11a-1p** - 2 hr web meeting	**Aug 17-18** - 2 day in-person meeting, HACs and readmissions, finalize WG input for September reports, begin work on quality issues in 11 settings		**Oct 18 11a-1p**- 2 hr web meeting **Oct 19 2-4p** - 2hr public webinar to update on all tasks	**Nov 1-2** - 2 day in-person meeting, finalize PAC report, finalize quality issues in 11 settings	**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework	Early Jan - 2-day in-person meeting to finalize pre-rulemaking input 1-2 week public comment period	**REPORT Feb 1st 15.1** Early Feb - informational public webinar Late Feb - 2 hr web meeting	Mid March - 2 day in-person meeting, finalize input on June reports		
Clinician Workgroup Coordination of measures for physician performance improvement (15.2a), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 7-8** - 2 day in-person meeting, framework, strategy for coordination of physician measurement, HACs & readmissions **June 30 1-3p** - 2 hr web meeting	July 13-14 or July 20-21 - 2 day in-person meeting to finalize strategy and themes for report on physician performance measurement, HACs & readmissions	late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.2a**	**Oct 19 2-4p** - 2hr public webinar to update on all tasks		**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework Dec 12 or 19 - 1 day in-person meeting to react to proposed measures						
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework					**Oct 19 2-4p** - 2hr public webinar to update on all tasks Early Oct - 2 hr web meeting?	**Oct 12-13** - 2 day in-person meeting to discuss hospital coordination framework and finalize measures for cancer hospitals	**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework **Dec 15** - 1 day in-person meeting to react to proposed measures				Early April - public webinar and 30 day comment period on draft cancer report	**REPORT June 1st 15.2c**	
Ad Hoc Workgroup HACs & readmissions (15.4)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 9-10** - 2 day in-person meeting with additional payers, consider HACs & readmissions, framework	July 11-12 (2 day) or July 12 (1 day) in-person meeting, review other groups' work on HACs and readmissions to finalize report on HACs & readmissions	late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.4**	**Oct 19 2-4p** - 2hr public webinar to update on all tasks								
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 2-3** - 1.5 or 2 day in-person meeting to discuss duals' quality issues, HACs & readmissions, framework	**July 6 11a-1p** - 2 hr web meeting **July 25-26** - 2 day in-person meeting to continue discussion of quality issues, finalize preliminary themes, HACs & readmissions		**Interim REPORT Sept 30th 15.3**	**Oct 19 2-4p** - 2hr public webinar to update on all tasks and 30-day comment period on interim report	Mid Nov - 1 day in-person meeting, present public and HHS feedback, begin next phase	**Dec 8 1-3p** - ALL groups on 2 hr web meeting to distribute measures with homework **Dec 16** - 2 hr web meeting to react to proposed measures	Late Jan - 2 hr web meeting	Mid Feb - 2 day in-person meeting to finalize measure concepts and themes for report		Early April - public webinar and 30 day comment period on draft duals report	**REPORT June 1st 15.3**	

Measures published **by CMS on December 1**

* All dates are tentative and highly subject to change. Bolded dates confirmed final.

HHS Task 15 - Timeline by Group -- REVISED May 10

DRAFT

Group	2011									2012					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Measu	Dec	Jan	Feb	Mar	Apr	May	Jun
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 28** - 1 day in-person meeting, consider HACs & readmissions, framework		Aug 9 (1-3p) or Aug 10 (11a-1p) - 2 hr web meeting	**Sep 8-9** - 2 day in-person meeting to discuss measures for PAC and coordination strategy	**Oct 19 2-4p** - 2hr public webinar to update on all tasks	Nov 21 (11a-1p), Nov 29 (1a- 3p), Dec 2 (10a-12p)- 30 day public comment period on PAC report and public webinar to introduce public comment on PAC report		**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework **Dec 14** - 1 day in-person meeting to react to proposed measures		**REPORT Feb 1st 15.2b** Mid Feb - 2 hr web meeting Late Feb - 2 day in-person meeting to finalize measures for hospice		Early April - public webinar and 30 day comment period on draft hospice report		**REPORT June 1st 15.2d**

* All dates are tentative and highly subject to change. Bolded dates confirmed final.

Member Responsibilities

Tab 6

NQF
NATIONAL QUALITY FORUM

Measure Applications Partnership
Member Responsibilities

- Strong commitment to advancing the performance measurement and accountability purposes of the Partnership.

- Willingness to work collaboratively with other Partnership members, respect differing views, and reach agreement on recommendations. Input should not be limited to specific interests, though sharing of interests is expected. Impact of decisions on all healthcare populations should be considered. Input should be analysis and solution-oriented, not reactionary.

- Ability to volunteer time and expertise as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad hoc groups.

- Commitment to attending meetings. Individuals selected for membership will not be allowed to send substitutes to meetings. Organizational representatives may request to send a substitute in exceptional circumstances and with advance notice. If an organizational representative is repeatedly absent, the chair may ask the organization to designate a different representative.

- Demonstration of respect for the Partnership's decision making process by not making public statements about issues under consideration until the Partnership has completed its deliberations.

- Acceptance of the Partnership's conflict of interest policy. Members will be required to publicly disclose their interests and any changes in their interests over time.

Adopted by the NQF Board of Directors on September 23, 2010

MAP Brochure

Tab 7

Measure Applications Partnership
Payment and Public Reporting

MAP

Americans cannot afford disjointed and inconsistent healthcare. Their dreams depend on healthy lives and on responsive, high-quality care when sickness comes. Their aspirations, as individuals and as a nation, depend on access to care with reasonable costs.

Performance measures move us toward care that is careful—careful to follow proven practices, use resources well, and focus on the patient's point of view. Performance measures will also be critical to achieving the priorities and goals of the soon-to-be-announced National Quality Strategy.

The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task. For that reason, the Patient Protection and Affordable Care Act directs the Secretary of Health and Human Services (HHS) to gain input from a consensus-based entity on the best measures to use in public reporting, value-based payment, and other programs.

In response to the Secretary's request, the National Quality Forum has established the Measure Applications Partnership. The MAP brings together stakeholder groups in a collaboration that balances the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. The MAP also includes individual representatives with deep expertise in key areas and liaisons from public sector programs.

While HHS may consult many sources before making decisions on measure choices, the MAP will be a unique voice, blending the perspectives of diverse stakeholders informed by evidence.

Why the MAP?

The MAP will:

- Identify best available measures for use in specific applications.
- Provide input to HHS on measures for use in public reporting, value-based payment, and other programs.
- Encourage alignment of public and private sector efforts.

A collaboration like the MAP is a wonderful way to achieve the broad support America needs to make the fundamental changes in the delivery system that will produce meaningful gains in the health of people and communities.

George Isham, MD, MS, Co-Chair, the MAP Coordinating Committee

How the MAP will support better, more affordable care

At a policy level, we must create an environment that spurs alignment of programs around national goals and priorities through the key drivers of public reporting, value-based payment, and the provision of knowledge and tools to support improvement. Helping policy-makers and practitioners select the best measures to use in each application is where the MAP comes in.

The MAP will:

STRENGTHEN PUBLIC REPORTING. Over the next several years, HHS will expand its Healthcare Compare websites to encompass a broader array of providers and include more information on their performance. Voters and their elected officials, patients and communities, clinicians, healthcare organizations, and every other stakeholder will have better information on which to base their choices. But the measures selected for these websites and other public reporting programs must provide meaningful and useful information that supports such decisions.

SUPPORT IMPROVEMENTS IN QUALITY AND AFFORDABILITY. Because measures will tell us what does and doesn't work to sustain health and treat health problems, providers and payers will have better yardsticks for identifying best practices and channeling resources to health systems capable of providing care that is safe and effective.

SERVE AS THE BASIS FOR PAYMENT, using models that align financial incentives with performance through Medicare and other publicly supported programs. Private payers will undoubtedly look to the MAP to drive their decisions on payment as well.

As requested by HHS, the MAP will first establish a framework that will guide the identification of performance measures for:

- Ambulatory practice settings.
- Post-acute settings, including long-term care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities, and home healthcare.
- Cancer hospitals exempt from the prospective payment system.

The MAP will also develop guidance on measures related to care for dual eligible beneficiaries and reduction of readmissions and healthcare-acquired infections.

What is the MAP?

The MAP is a collaboration:

- Engaging more than 60 organizations representing major stakeholder groups; 40 individual experts; and eight federal agencies.
- Governed by a multi-stakeholder Coordinating Committee.
- Convened by the National Quality Forum.

The MAP will build on the remarkable work done for well over a decade to develop measures that can help us bring greater value into healthcare. We now have hundreds of measures. Our challenge is to help users pick the right ones for their application.

Elizabeth McGlynn, PhD, MPP, Co-Chair, the MAP Coordinating Committee

The MAP criteria

In each case, the appropriate MAP workgroup will:

- Consider measures already associated with the request for input. NQF will construct a catalog of current measures and analyze them for convergence and divergence and for alignment with the national goals.
- Identify a potential set of core measures, noting which ones are currently available and where gaps need to be filled.
- Look for ways to develop a more coordinated approach to measurement in the requested area.
- Provide input to the MAP Coordinating Committee, which will in turn provide guidance to HHS.

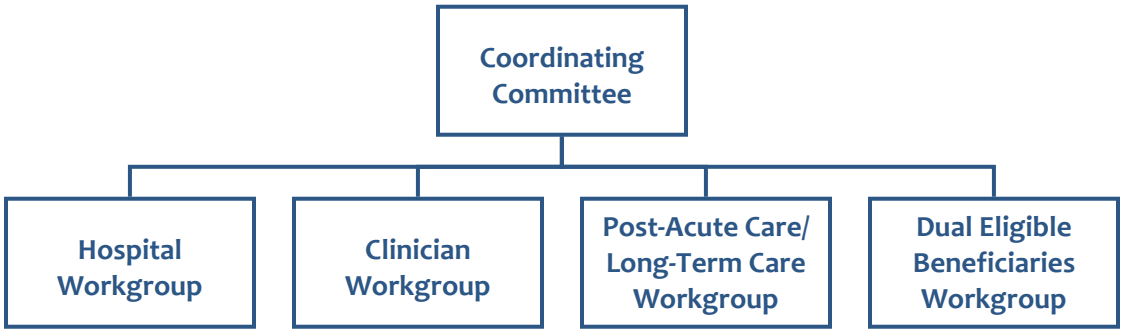
A few guiding principles

The MAP will:

- Use the priorities and goals of the National Quality Strategy *(soon to be announced)* to set its course.
- Give explicit consideration to the special issues of dual-eligible populations.
- Reinforce alignment across settings and between public and private efforts.
- Base recommendations on the latest science and evidence from the field.

How the MAP will work

The new partnership will operate through a two-tiered structure. A Coordinating Committee will provide direction. Four workgroups will advise the Coordinating Committee on measures needed for specific types of programs. Each workgroup will include individuals with content expertise and organizations particularly affected by that group's area of work.



The MAP will operate in a thoroughly transparent manner, broadcasting meetings, posting meeting summaries on the Web, and soliciting and responding to public comments. The MAP has already put this principle to work in every aspect of its start-up. As was the case for initial appointments, the MAP will continue to seek public nominations and comments on proposed members whenever slots open on the Coordinating Committee and work groups. While NQF convenes and staffs the MAP, the Coordinating Committee will provide guidance directly to the Department of Health and Human Services, not the NQF Board.

Working in concert

For more than a decade, the National Quality Forum has brought stakeholders together to bring strong measurement into the service of patients and communities. Its process for endorsement of best-in-class measures supports open dialogue among diverse members while it retains its grounding in science and evidence of impact. In 2008, NQF convened the National Priorities Partnership, which is now providing input to HHS on priorities and goals.

The MAP and the National Priorities Partnership focus their workgroups on different activities, but the two are closely aligned. The MAP identifies measures for specific applications such as public reporting and value-based payment; while NPP, within its broader brief, identifies more global measures of progress on the national priorities.

Over the last year, NQF has moved aggressively to support payment reform and public reporting by identifying gaps in measurement that must be filled; to accelerate the endorsement and review of measures in priority areas; and to recommend a framework for the choice of measures to assess "meaningful use" of health information technology. All of these activities will inform the work of the MAP and the National Priorities Partnership through overarching alignment with the National Quality Strategy.

What we see ahead

Performance measures give us a way to gauge improvements in our health and the quality of our healthcare. When well chosen, they can be powerful tools to make the course corrections our healthcare system so badly needs: coordinated care that centers on patients and families; focus on the chronic conditions that do so much to undermine health; and payment that correlates with performance. We will not achieve precise calibration overnight; but with its focus on measurement and alignment, the National Quality Strategy moves us in the right direction.

To learn more about the MAP, visit qualityforum.org.

This overview was prepared with support from the Robert Wood Johnson Foundation.

RAND Report – Executive Summary

Tab 8

Payment Reform: Analysis of Models and Performance Measurement Implications
Draft Executive Summary
September 28, 2010

I. Executive Summary

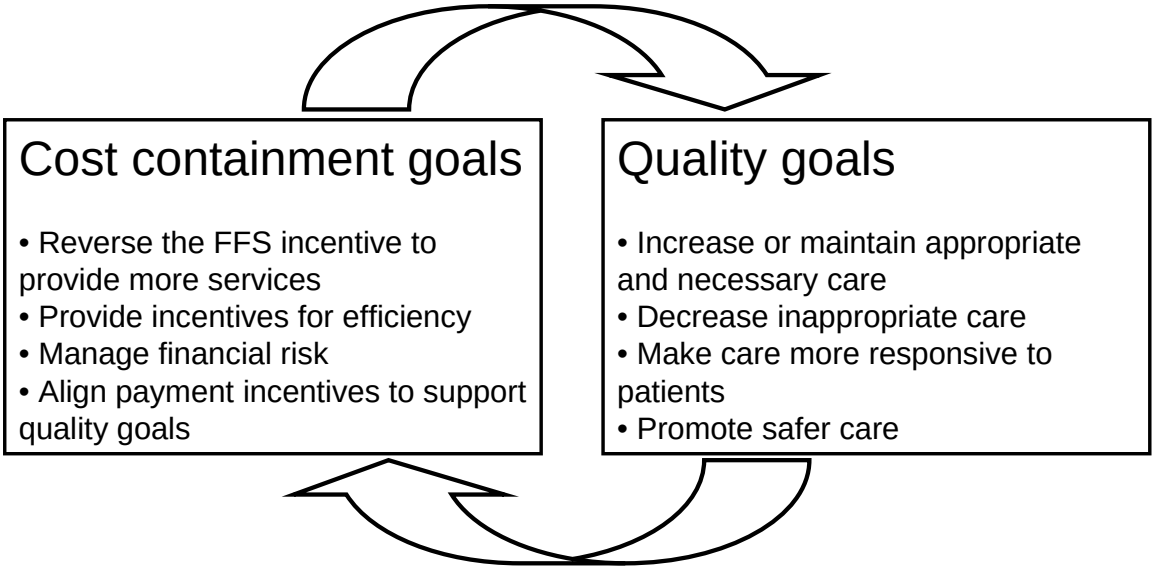
A. Background

Insurers and purchasers of health care in the United States are on the verge of potentially revolutionary changes in the approaches they use to pay for health care.[1] Since at least the 1980's, the traditional and predominant fee-for-service payment model has been altered or joined by payment reforms including prospective payment for hospitals in the 1980's and health plan and medical group capitation in the 1990's. Yet critics continue to assert that the persistent use of fee-for-service payment motivates increases in the volume and intensity of services without enhancing the quality of care or its efficiency. In addition, critics argue that fee-for-service payment does not foster coordination of care across providers and care delivery organizations and may contribute to the overuse of services with little or no health benefit. [2-3]

In the past decade, purchasers and insurers have increasingly experimented with payment approaches that increase incentives to improve quality and reduce the use of unnecessary and costly services.[3-5] The federal government has given a new impetus to these payment approaches within the Patient Protection and Affordable Care Act (PPACA) of 2010.[6] These payment approaches are designed to achieve two interrelated goals: quality improvement and cost containment (Figure ES1). Cost containment is to be achieved by reversing the incentives under fee-for-service payment to increase the use of services by shifting some amount of financial risk to providers, spurring them to consider the costs of their decisions. The introduction of financial risk in payment models may have mixed consequences for quality. On the one hand, financial risk may promote high quality by motivating providers to reduce rates of overuse of inappropriate services. On the other hand, financial risk may lead providers to reduce services that are important to high quality care or impede access to care.

To address the risks to quality that may emerge in the transition away from fee-for-service payment, proposed new payment reform models do more than simply introduce capitation payments. They include explicit measures of quality and tie payment to performance on those measures so that quality improvement will be driven by financial incentives to providers for the use of clinically appropriate services, efforts to make care more patient-centered through coordination and integration of a patient's care among providers, and incentives to invest in patient safety.

Figure ES1. Goals of Payment Reform Models



As this discussion implies, payment reform models will have to be designed and implemented carefully in order to ensure that both the cost containment and quality goals are achieved. Furthermore, performance measurement and reporting are a crucial component of new payment models. The potential reliance on performance measures to address both cost containment and quality goals is already placing new demands on the performance measure development enterprise. Measures will be needed to perform several important functions in new payment systems, including two that are central to this report:

- *Setting performance-based payment incentives.* New payment reform models typically create performance incentives by adjusting payment amounts based on measured performance (e.g., determining whether a payment occurs and the amount of a payment, or determining non-payment for services if they are linked to poor quality care).

- *Protecting against unintended adverse consequences of cost containment.* Payment reform models may create unintended adverse consequences such as avoidance of some high-risk or high-cost patients by providers, other barriers to access, and underuse of evidence-based services. Measurement approaches will be needed to identify and ameliorate these unintended consequences.

The purpose of this report is to provide information about the current status of performance measurement in the context of payment reform and to identify near-term opportunities for performance measure development. The report is intended for the many stakeholders tasked with outlining a national quality strategy in the wake of health care reform legislation. Through a subcontract to the National Quality Forum, a team of investigators at RAND used a rigorous and selective process to create a catalog of payment reform programs including demonstration projects as well as those outlined in legislation. Based on the features of these programs, each was categorized into one of eleven payment reform models. Next, each model and its programs were analyzed to describe the rationale for performance measurement, identify the performance measures available to the model, and assess its unmet measure needs. Finally, a set of near-

term measure development opportunities and implementation challenges were explored to inform the direction of future measure development.

The uses of performance measurement and reporting in health care is a vast and complex topic. Performance measures have many other functions in addition to their use to set payment incentives. Of necessity, this report focuses on the two functions noted above and limits the scope of discussion to these functions. The report does not address the following issues:

- *Measures of "financial performance" such as total spending on services or resource use that may be used by payers to negotiate payment amounts with providers are not addressed.* These "accounting" measures are a focus of the report only if they are closely linked to quality measures within an efficiency framework.

- *Other applications of performance measurement and reporting are not addressed unless they are an intrinsic part of the payment reform models.* These other applications include the use of performance measures to:

    - Identify opportunities to improve performance
    - Monitor progress toward improvement goals
    - Inform consumers/purchasers to enable selection of providers
    - Stimulate competition among providers
    - Stimulate innovation
    - Promote the "values" of the health system

- *Variations in the implementation of actual incentives and the distribution of payments between health plans, hospitals, provider groups, and individual providers are beyond the scope of the report.* Many payment models are complex and not yet fully specified making it difficult to assume any special configuration of payers, providers, and incentives. However, where such configurations would affect performance measure development and implementation, we note this.

- *Payment reform models relevant to hospitals, physicians, and other medical providers are emphasized.* Long-term care, home health, ambulatory surgery, and many other delivery organizations are obviously critically important. These organizations have participated in payment reform experiments, and they are addressed in health reform legislation. Nevertheless, to make the scope of the discussion manageable we have elected to focus on hospital and physician payment reform models. Results and lessons from these models could be applicable to payment reform programs developed for these other organizations.

B. Key findings

Payment reform models

- We identified and catalogued 90 payment reform *programs,* classifying them into eleven general payment reform *models*

- The payment reform models are diverse with respect to the targeting of payment to performance goals, the bundling of services, and the level at which payment is made to organizations and individual providers

- While three types of care delivery entities have been prominently featured in payment reform models (the hospital, the ambulatory group practice, and the individual physician), performance-based payment reform will involve other types of providers (long-term care, ambulatory surgical centers, and others)

- Payment reform programs frequently blend elements of the eleven payment reform models

- Additional blending of payment reform models seems likely as programs are implemented in the future

Implications of the use of performance measurement to support the emerging payment reform models.

- The number and sophistication of measures in use varies widely across programs within each payment reform model suggesting ongoing experimentation to determine optimal approaches

- Many available performance measures are not yet in use in current payment reform programs

- Measure development should be guided by a longitudinal care framework rather than a focus on discrete clinical services

- Complex organizational types may benefit from complex measurement strategies that support internal incentive and quality improvement models

- Composite measures will be important, especially in assessing episodes of care

- Efficiency of care measures may be useful in payment reform models that are not based on global or capitated payment

- Blended payment models will rely on blended performance measurement strategies

- Structure of care measures will be required for some models, at least in the near term

Priority areas for further measure development

The following measure types offer promising opportunities for further measure development and refinement across many of the payment reform models we identified:

- Health outcome measures that can be used to assess care for populations:

  - Health status measures (functional status and quality of life)

  - Safety outcomes (preventable harms attributable to health care)

- Care coordination measures (including measures that assess care transitions)
- Measures of patient and caregiver engagement (measures that assess the participation of patients and caregivers in their care)
- Measures of structure (particularly management measures and HIT utilization measures that address new organizational types)
- Composite measures that combine outcome, process, structure, patient experience, cost and other measure types
- Efficiency measures that combine quality and resource use measures

To minimize the risk that new payment reform models will increase disparities in care, additional measure development may be useful in two specific areas:

- Clinical and sociodemographic risk profiles of providers' patient populations
- Measures of access to care and measures to detect provider avoidance of high-risk patients

C. Project Methods

The goal of the project was to describe the performance measurement needs created by current and emerging payment reform approaches, to assess the suitability of existing performance measures to support these needs, and to suggest near-term priority areas for performance measure development that would support these needs effectively going forward. To achieve the goal, RAND, in consultation with NQF staff, carried out the following tasks (see Figure ES2):

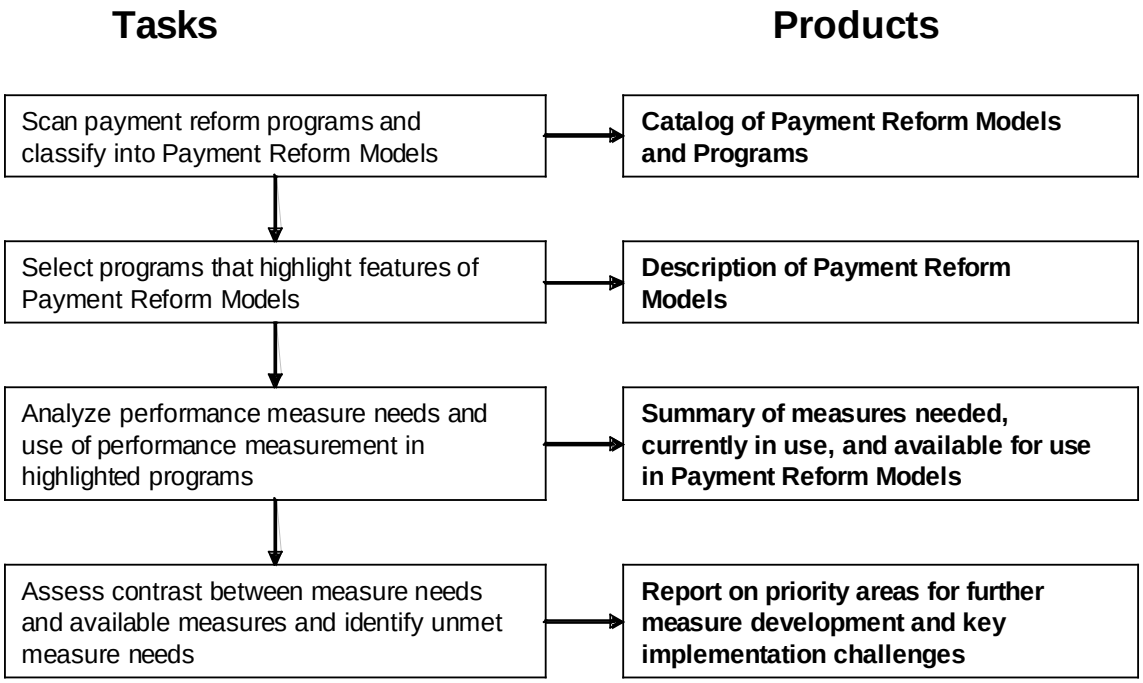
- Scan of payment reform programs to derive Payment Reform Models (PRMs)
- Selection of payment reform programs to highlight features of PRMs
- Analysis of performance measure needs and suitability of available performance measures
- Assessment of the gap between measure needs and available measures to identify unmet measure needs

For each PRM we described:

- The rationale guiding selection of performance measures and payment-incentive-specific use of measurement in the payment reform model
- An overview of the use of performance measurement in the highlighted payment reform programs
- An analysis of the suitability of available measures

We then summarized these findings across payment reform models, including key gaps in available measures and common implementation challenges associated with performance measurement under the reforms.

Figure ES2. Tasks and Products



D. Results

We grouped the reviewed payment reform programs into eleven Payment Reform Models (PRMs) that create demand for performance measures (Table ES1).

These eleven models vary widely in the extent to which they alter current payment methods, the scope of patients and services affected, and the providers subject to the new payment arrangements. Therefore, the model incentives and purposes of performance measurement also vary substantially between models. Even within a particular model, different implementations may vary widely on these dimensions. However, there are some general patterns of relationships between the models that can be helpful in comparing their performance measurement needs.

Table ES1. Description of Payment Reform Models and Uses of Performance Measures

Payment Reform Model	Brief Description	Payment-incentive-specific uses of performance measurement
Model 1. Global Payment	A single per-member per-month payment is made for all services delivered to a patient, with payment adjustments based on measured performance and patient risk.	1. Determining based on measured performance whether bonus payments will be made, and the amount of those payments (using a P4P mechanism). 2. Assessing negative consequences, such as avoidance of patients with complex conditions, greater severity of disease, or other risk factors. 3. Informing strategic decisions by payers about the design and implementation of the payment program. (e.g., assessing the impact of the payment model on cost and quality). 4. Assisting providers to identify opportunities for quality improvement and greater efficiency of care delivery.
Model 2. ACO shared savings program	Groups of providers that voluntarily assume responsibility for the care of a population of patients (known as Accountable Care Organizations or ACOs) share payer savings if they meet quality and cost performance benchmarks.	*Similar to global payment model*
Model 3. Medical Home	A physician practice or other provider is eligible to receive additional payments if medical home criteria are met. Payment may include calculations based on quality and cost performance using a P4P-like mechanism.	1. Evaluating whether practices meet medical home qualification criteria, which may include multiple tiers of achievement. 2. Evaluating practice impact on quality and resource use. 3. Supporting practice-based quality improvement activities.
Model 4. Bundled Payment	A single "bundled" payment, which may include multiple providers in multiple care settings, is made for services delivered during an episode of care related to a medical condition or procedure.	1. Making adjustments to providers' episode-based payment rates based on quality of care. 2. Determining whether providers meet performance criteria for participation in a bundled payment program. 3. Assessing negative consequences, including avoidance of certain types of patients or cases, particularly through patient experience measures. 4. Assisting providers to identify opportunities for quality improvement and greater efficiency of care delivery.

Table ES1. Description of Payment Reform Models and Uses of Performance Measures

Payment Reform Model	Brief Description	Payment-incentive-specific uses of performance measurement
Model 5. Hospital-Physician Gainsharing	Hospitals are permitted to provide payments to physicians that represent a share of savings resulting from collaborative efforts between the hospital and physicians to improve quality and efficiency.	1. Determining if hospitals and affiliated physicians are eligible to participate in a gainsharing program. 2. Ensuring that the quality of patient care is not compromised. 3. Ensuring that the payment incentives lead to improved hospital operational and financial performance (e.g. efficiency). 4. Detecting increases in the volume of referrals for services not covered within the gainsharing arrangement. 5. Assessing adverse consequences such as hospital or physician avoidance of patients with adverse risk characteristics. 6. Making information available to providers about opportunities for improvement.
Model 6. Payment for Coordination	Payments are made to providers furnishing care coordination services that integrate care between providers.	1. Determining whether providers receive performance-related bonuses (in some programs). 2. Evaluating the effectiveness of programs that seek to improve coordination-related performance. The approaches taken by programs within this PRM have tended to offer flexible financing to multidisciplinary teams of providers, and then measure cost and health outcome measures to assess how cost and quality change over time. 3. Assessing negative consequences, including avoidance of certain types of patients or cases, particularly through patient experience measures. 4. Assisting providers to identify opportunities for quality improvement and greater efficiency of care delivery.
Model 7. Hospital P4P	Hospitals receive differential payments for meeting or missing performance benchmarks.	1. Determining eligibility for participation in P4P programs. 2. Determining the amount of bonus payments or adjustments to the DRG payment schedule. 3. Measuring unintended adverse consequences of the payment reform model and monitoring performance trends in areas not targeted by P4P. 4. Assisting hospitals to identify opportunities for quality improvement and greater efficiency of care delivery.

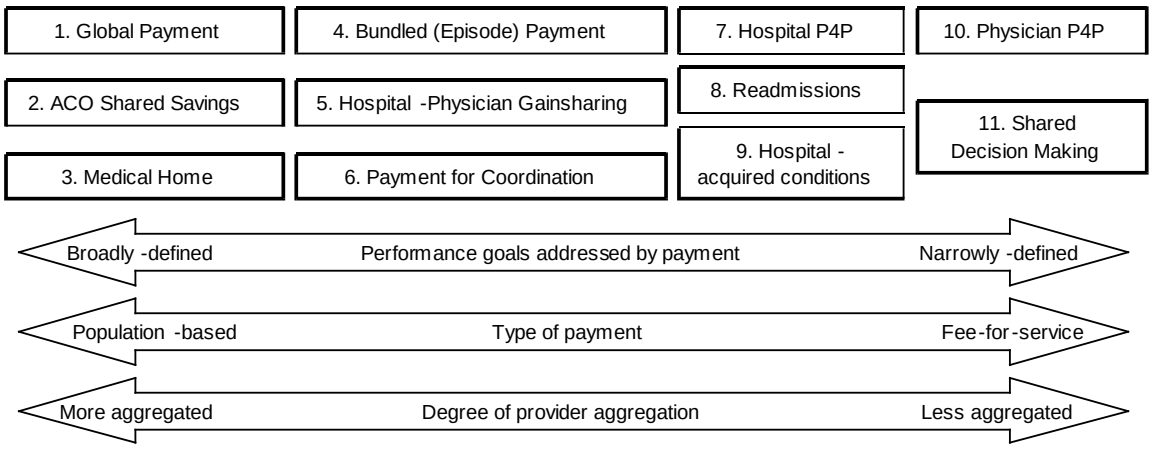
Table ES1. Description of Payment Reform Models and Uses of Performance Measures

Payment Reform Model	Brief Description	Payment-incentive-specific uses of performance measurement
Model 8. Payment adjustment for readmissions	Payments to hospitals are adjusted based on the rate of potentially avoidable readmissions.	1. Determining which readmissions are considered preventable 2. Determining which hospitals will be subjected to a payment penalty 3. Assisting hospitals to identify opportunities to improve the discharge transition. 4. Measuring unintended adverse consequences of the payment reform model such as assignment of admitting diagnoses to avoid the penalty.
Model 9. Payment adjustment for hospital-acquired conditions	Hospitals with high rates of hospital-acquired conditions are subject to a payment penalty, or treatment of hospital-acquired conditions or serious reportable events is not reimbursed.	1. Determining whether a payment is adjusted. 2. Assisting hospitals to identify opportunities to improve safety. 3. Measuring unintended adverse consequences of the payment reform model and monitoring performance trends in areas not targeted by the payment adjustment.
Model 10. Physician P4P	Physicians receive differential payments for meeting or missing performance benchmarks.	1. Determining adjustments to bonus payments or to fee-schedules. 2. Measuring unintended adverse consequences of payment models and monitoring trends in performance for areas not targeted by P4P. 3. Identifying opportunities for quality improvement.
Model 11. Payment for Shared Decision-Making	Payment is made for the provision of shared decision-making services.	1. Evaluate the use of shared decision-making tools in improving patient decision making and better aligning treatment choices with patient preferences. 2. Certification of patient decision aids. 3. Assessing the potential for unintended adverse consequences of tying payments to shared-decision making process. 4.

Figure ES3 arrays the eleven models along three dimensions relevant to potential measurement strategies, reporting, and performance-based payments:

(1) Whether performance targets addressed by the payment define a broadly-specified group of services (e.g., all care provided to a patient) or a narrowly selected set of services (e.g., shared decision making),
(2) Whether a payment is intended to cover a population, a bundle of services, or a specific service, and
(3) The degree of aggregation of providers for the purpose of payment and measurement.

Figure ES3. Continuum of Payment Reform Models



The payment reform models at the leftmost end of the figure represent payment made to a group of providers and/or provider organizations to provide high quality and efficient care to a defined population over time. The performance goals generally include a broader and more comprehensive set of services than the goals defined for the models to the right of the diagram. The payment reform models at left end of the spectrum may incorporate and combine elements of payment reform models from the right side of the spectrum. At the rightmost end of the spectrum, payment is generally used to achieve relatively narrowly defined performance goals and the payment is more frequently made to individual providers rather than groups. Payment reform models in the middle of the spectrum are blended with respect to each of the three dimensions. These models generally focus payment on specific sets (e.g., bundles) of services that are delivered during an episode of care.

Below, we briefly describe the near-term performance measurement needs defined by each payment reform model. The lists of near-term performance measurement needs are not intended to be comprehensive or exclusive. It is possible to imagine for each payment reform model a program that included all possible measures. Because the devotion of resources to measure development and implementation is likely to be limited, such a perspective would be uninformative. Instead, we have selected those measure needs that are likely to be of greatest interest within the context of each specific payment reform model.

Table ES2. The Special Performance Measure Needs created by Payment Reform Models

Payment Reform Model	Special Performance Measurement Needs of Payment Model
Model 1. Global Payment	1. Reflect the broad range of care services delivered and multiple care delivery settings that participate in providing care to a population under the global payment (i.e. measures for physician groups, hospitals, emergency departments, post-acute care, and any other setting that may provide care under the global payment). 2. Include key indicators (such as health outcomes attributable to the care provided under the global payment), composite measures, or measure sets.. 3. Enable longitudinal, population-based measurement of the care services provided to the population covered by the global payment. 4. Can be used within or across global payment programs that vary with respect to a. the length of the time period addressed by longitudinal measurement and whether this time period is fixed or variable, b. the provider holding the global payment (e.g., integrated delivery system, hospital, or ambulatory provider group) c. the range of providers that participate in the global payment, and d. the range of services providers deliver under the global payment.
Model 2. ACO shared savings program	1. Reflect the broad range of care services delivered and multiple care delivery settings that participate in the ACO (i.e. measures for physician groups, hospitals, emergency departments, post-acute care, and any other setting that may be included in the ACO). 2. Include key indicators (such as health outcomes attributable to the care provided under the global payment), composite measures, or measure sets.. 3. Enable longitudinal, population-based measurement of the care services provided to the population enrolled in the ACO. 4. Can be used within or across ACOs that vary with respect to a. the length of the time period addressed by longitudinal measurement and whether this time period is fixed or variable, b. the features of the ACO management responsible for allocating the shared savings (e.g., integrated delivery system, hospital, or ambulatory provider group) c. the range of providers that participate in the ACO, and d. the range of services providers deliver within the ACO.

Table ES2. The Special Performance Measure Needs created by Payment Reform Models

Payment Reform Model	Special Performance Measurement Needs of Payment Model
Model 3. Medical Home	1. Reflect the adoption of care processes and structural capabilities (management features and health information technology) that enhance continuity and coordination of care. The Medical Home model relies on the adoption of care processes and structures that enhance continuity and coordination of care, and create incentives for providers to deliver care in ways that are poorly compensated through the traditional fee-for-service system. Therefore, medical home programs specify performance measures that target these care processes and practice structural capabilities. 2. Assess whether care is patient-centered, including the outcomes of primary care, the patient experience, and patient and caregiver engagement with primary care. These measures can ensure that the transformations promoted under the Medical Home model produce more efficient and patient-centered care.
Model 4. Bundled Payment	1. Are related to the conditions targeted by the bundles. 2. Are tailored to the care delivery settings that participate in delivering components of the care bundle (i.e. measures for hospitals as well as for individual physicians), or that can be used effectively across multiple care delivery settings in an episode-of-care framework. 3. Can be used to detect negative consequences of the payment model (e.g., bundle-specific measures of appropriateness of care and the patient experience of care). 4. Assess coordination of care within and across episodes (or bundles).
Model 5. Hospital-Physician Gainsharing	1. Apply to both the hospital and individual physicians covered by the gainsharing arrangement. 2. Evaluate the specific treatments or procedures covered by the gainsharing arrangement. 3. Are treatment-specific or procedure-specific, particularly to evaluate adverse consequences such as avoidance of high-risk patients. 4. Include patient health and safety outcomes. Measures of process should be chosen carefully to avoid the potential to “lock in” care processes that have acceptable or superior substitutes. 5. Assess care coordination, access, cost, and utilization.
Model 6. Payment for Coordination	1. Assess whether care coordination activities are accomplished. 2. Assess costs, service utilization, patient experience, and health outcomes of patients who receive care coordination services.

Table ES2. The Special Performance Measure Needs created by Payment Reform Models

Payment Reform Model	Special Performance Measurement Needs of Payment Model
Model 7. Hospital P4P	1. Measure sets may be narrowly or broadly defined depending on the number of performance goals included in the performance incentive. 2. A narrowly constructed set may focus on a specific domain of measurement, such as healthcare-associated infections. Other P4P measure sets may focus on patient outcomes, patient experience, costs of care, or access to care. For example, measurement may focus on the evidence-based safety processes associated with avoidance of preventable complications, such as healthcare-associated infections (HAI). 3. A broadly constructed measure set will blend payment incentives on measures from multiple domains. 4. P4P programs may also be included as components of other payment reform models such as the global payment or ACO shared savings PRMs. Hospital P4P may also be layered on top of a bundled payment program with hospital episodes defining bundles of care and performance measures defining the P4P adjustment to a bundled payment. 5. Structural capabilities of a hospital or credentials of hospital-based clinicians may determine eligibility for participation in a P4P program or eligibility for a differential payment.
Model 8. Payment adjustment for readmissions	1. Emphasize aspects of care under the hospital's control and account for the clinical and sociodemographic risk characteristics of the hospital's patient population 2. Can be used to assess adverse outcomes (such as patient experience measures) 3. Can be used to understand the processes that influence the risk of readmission and can help to redesign the discharge transition to reduce readmission rates
Model 9. Payment adjustment for hospital-acquired conditions	1. Enable identification and documentation of the occurrence of hospital-acquired conditions (e.g., treatment complications and other safety outcomes). Performance measurement within this model is used to document the occurrences of preventable hospital-acquired conditions. While the NQF publishes a list of Serious Reportable Events that are considered preventable, these are rare events. 2. Provide an assessment of the preventability of these conditions. Hospital-acquired conditions used in measurement should be associated with evidence that they are preventable.[7] 3. Enable meaningful aggregation of conditions to form composite measures. In addition, measures of safety processes that can prevent such events may enable stakeholders to implement the PRM so that over time, it is more likely to reduce the incidence of hospital acquired conditions.

Table ES2. The Special Performance Measure Needs created by Payment Reform Models

Payment Reform Model	Special Performance Measurement Needs of Payment Model
Model 10. Physician P4P	1. Assess delivery of evidence-based chronic disease management including care processes, patient outcomes, patient experience, and access to care. 2. Include composites of measures across conditions to assure that clinicians do not focus on some aspects of care delivery to the detriment of others. 3. Assess structural capabilities of physician practices to determine eligibility to participate in a P4P program or eligibility for a differential payment. 4. Can be used to evaluate the quality of episodes of care (in combination with the bundled payment model). 5. Assess the appropriateness of care and efficiency of care delivery.
Model 11. Payment for Shared Decision-Making	1. Can be used to assess patient and caregiver experience and patient and caregiver engagement. 2. Include structural aspects of care such as criteria for the certification of patient decision aids. 3. Assess the process used to enable shared decision-making.

E. The potential impact of payment reform models on performance measure development

Any portfolio of performance measures generally reflects those quality problems that are concerning to health care stakeholders. Frequently, the concerns arise in relation to the payment mechanisms used to purchase health care services. During the past decade, performance measure developers have tended to specify measures for either a fee-for-service payment environment or a capitated health plan environment. Early efforts to develop measures for use in capitated health plans tended to focus on assessing underuse of preventive services and chronic care. Fewer measures focused on inappropriate service delivery and very few prior measurement efforts have addressed the efficiency of care delivery.

Our analysis suggests that new initiatives to base payment on performance measurement may create a new set of demands on performance measure developers.
There are several implications of the shift to a focus on measurement to support the emerging payment reform models.

- *Measure development should be guided by a longitudinal care framework rather than a discrete service focus*

  Many past performance measures have tended to focus on the delivery of discrete clinical services such as preventive services, medications, or other treatments delivered at a specific point in time. Exceptions include the chronic disease measurement sets that address care processes delivered during a time frame. Some of the payment reform models we studied rest on a longitudinal care framework (Global Payment, ACO Shared Savings, Medical Home, Bundled Payment and Hospital-Physician Gainsharing). Episode-based measurement is not a new construct. Risk-adjusted mortality after hospitalization or surgery is an outcome measure that is used to assess an episode of hospitalization or surgery. However, developing and refining a variety of quality measures to address episodes of care will be an important step. Using a longitudinal measurement framework to develop measures will enable an emphasis on health outcomes. In particular, the measurement of changes in functional status, morbidity, and quality of life will be attractive. The selection of process measure sets should also be informed by the longitudinal framework.

- *Complex organizational types may benefit from complex measurement strategies that support internal incentive and quality improvement models*

  Some of the payment reform models encompass a broad range of clinical activities and organizational types that must coordinate with one another (e.g., the Global Payment and the ACO Shared Savings) in contrast to others that target relatively narrowly specified goals for a specific organizational type (e.g., reducing hospital-acquired conditions or promoting the use of shared decision-making tools). Although it is also possible to set performance incentives on a few key indicators (e.g., population outcomes), the complex organizational types may have expansive measure needs in order to set incentives to providers internally (including outcome,

process, and other measure types). While each organization could develop its own measures for internal use, non-standardized measurement approaches may defeat the use of results for other purposes (such as public reporting). Standardized measures of outcome and process that can serve P4P and other payment reform models (independent of the ACO or medical home context) will also be useful to complex organizations.

Priorities for measure development may be unclear until these delivery models and their patient populations are more specifically defined. For example, it will be difficult to specify measures for an ACO without knowing the range of providers and delivery organizations that will participate. The creation of composite measures may be especially challenging until the ACO organization is better defined.

- *Composite measures will be important in an episode-based payment framework*

  Composite measures that combine clinical process measures or process and outcome measures longitudinally will be desirable in an episode-based measurement framework. A recent paper summarizes some of the considerations in choosing composite measure sets for specific purposes.[8]

- *Efficiency of care measures may be useful*

  Containing costs is a goal of most of the payment reform models either directly (through the fixed base payment of models like the global payment PRM) or indirectly (through bonuses that improve quality and reduce the need for future care such as the physician P4P). While assessment of costs may be necessary to set or negotiate payment amounts, measurement of costs is not necessary once a cost-containing incentive is established. In the context of the cost-containing incentive, performance measurement is used primarily to counteract the potential quality deficits that could arise from actions taken to reduce costs (e.g. reducing services). Given the challenges of developing measures of efficiency some observers have favored measuring cost or resource use (especially relative resource use). Cost and resource use can be difficult to interpret in the absence of accompanying measures of quality (to form efficiency measures) or case-mix or risk adjustment. Setting payment adjustments based on reductions in resource use or cost may undermine quality.

  Identifying and rewarding efficient care is desirable. Efficiency measures could be useful.[9] However, few efficiency measures have been developed to date and such measures are very challenging to develop. Measuring appropriateness or overuse of services can be useful in some of the payment reform models (e.g., hospital and Physician P4P). For example, pay-for-performance bonuses could be set based on efficiency measure results. The bundled payment PRM requires payers to establish payment amounts that account for the cost of a bundle of services delivered efficiently. Thus the bundle includes an implicit efficiency consideration by defining an optimal set of services (and their associated cost) to set a payment rate. Gainsharing programs set implicit targets related to cost, but do not define efficiency explicitly.

- *Blended payment models will rely on blended measurement strategies*

Where payment models are blended the measurement strategies may be adapted across models. Addition of pay-for-performance to a global payment strategy has been accomplished under the Alternative Quality Contract of Blue Cross Blue Shield of Massachusetts. Likewise, the use of bundled payment may be readily combined with other payment models. The measures developed for use in these other payment models can be readily integrated into the more complex payment models.

- *Structure of care measures will be required for some models, at least in the near term*

  Some payment reform models will require "structure of care" measures, at least in the near term. Some of these will take the traditional form of structure used in accreditation programs. These typically assess the presence or absence of a feature without further assessing its functionality. For example, computerized order entry systems can be present, but not used. The recent approach in legislation that defines "meaningful use" of health IT (translated by the Department of HHS into operational criteria for functionality) represents an example of this more sophisticated approach to assessing the structure of care.[10] The Medical Home, Payment for Care Coordination, and Payment for Shared Decision-Making models require the specification of criteria to enable certification that a provider or organization has basic capabilities. Medical home criteria define capabilities related to care management, access, and health information technology. Shared decision-making payments will depend on the use of certified decision aids and possibly processes, and payments for care coordination will require criteria for certifying the coordinating provider or organization.

F. Conclusions

The federal health care reform legislation of 2010 is likely to accelerate payment reform based on performance measurement. This report is intended to inform multiple stakeholders about the principal payment reform models and the status of performance measures in these models and programs. The report summarizes the characteristics of payment reform models and the performance measure needs they will generate. Finally, the report identifies the near-term measure development opportunities that may best accelerate the successful implementation of performance measurement in these models.

The report is also intended to create a shared framework for analysis of future performance measurement opportunities. Much measure development, implementation, and evaluation remains to be accomplished. Even for models with a track record of implemented programs and evaluation (such as the Hospital and Physician Pay-for-Performance models), measure sets have not reached their full potential. These programs were important first steps showing that payment based on performance is feasible even with the relatively limited measure sets available today. Barriers to a fully operational performance measurement system in health care can be overcome with careful planning and integration of care delivery systems, investments in measure

development and testing, and investments in the development of valid and reliable data sources that have adequate clinical data to support new measures.

Ongoing and planned demonstration projects and their evaluations will offer valuable lessons about the measures needed to implement these and future payment reform models. Carefully bridging payment reform and performance measurement while attending to the potential adverse unintended consequences should optimize the health of Americans and assure that care is affordable in the future.

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