The Significant Lack of Alignment Across State and Regional Health Measure Sets

Health Care Performance Measurement Activity:
An Analysis of 48 State and Regional Measure Sets

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Introduction: Private and public purchasers are interested in changing the way that they pay for health benefits by moving from a volume-based fee-for-service system to a system that pays for value. They argue that this movement will improve quality and reduce costs. Fundamental to value-based payment systems are performance measures that can assess to what extent the providers are achieving these twin goals. Recognizing that implementing the right measures is critical to the success of a value-based payment system, the Buying Value initiative, a coalition of employers, business health organizations and union health funds, has been working with CMS and private payers, i.e., health plans, to create a recommended measure set for use in such efforts. In beginning its work, the group quickly realized that before making a new contribution to the measurement world, it needed to have a better understanding of the measurement landscape across the states. Therefore, it commissioned Bailit Health Purchasing, LLC (Bailit) to conduct an analysis of a broad array of state-organized measure sets. Bailit gathered 48 measure sets representing different program types, and designed for different purposes, across 25 different states and three regional collaboratives.

Methodology: In identifying the 48 measure sets for the analysis, Bailit used a convenience sampling approach. Bailit requested assistance from contacts in various states, collected sets from state websites and solicited measure set recommendations from the members of the Buying Value initiative. It is important to note that Bailit did not survey every state, nor did it capture all of the sets used by the studied states. In addition, insurer and provider-organized measure sets were not studied. However, three measure sets from regional collaboratives were included in the analysis. Bailit, after consultation with Buying Value, excluded hospital-focused measure sets and removed 53 hospital-focused measures from the sets used in the analysis.

The goal of the analysis was to provide basic summary information to describe the 48 measure sets and assess the extent of alignment across the measure sets. The analysis sought to answer the following questions:

1. Are the measures used primarily standard measures?
2. To what extent are measures NQF-endorsed?
3. What are the primary sources of the measures?
4. Into which domains do most of the measures fall?
5. To what extent do the measures cover all age ranges?
6. To what extent are measures shared?
7. What are the most frequently shared measures?

Key Findings:

1. **There are many state/regional performance measures for providers in use today.** Across the 48 measure sets, we identified a staggering 1367 in use. When we looked at the "distinct"[1] measures across these sets, removing all of the duplicates across and within measure sets, we identified 509 distinct measures. Using the National Quality Strategy (NQS) tagging taxonomy developed by NQF, we found that these measures were distributed relatively evenly across all domains, with a focus on the "Treatment and Secondary Prevention" measures and the "Health and Well-being" measures. We also found that most measures are created for adults, but there does not appear to be a deficiency in the number of measures that could be used for the pediatric population or specifically for the age 65+ population.

2. **There is little alignment across measures sets.** State and regional measure sets don't "share" very many measures, meaning that they have very few measures in common. Only 20% of all measures were used by more than one program. Additionally the programs do not share these "shared measures" very often. No measure was used by every program. Breast cancer screening is the most frequently used measure and it is used by only 63% of the programs.[2] Only 19 measures were used by at least 1/3 of the programs.

3. **Non-alignment persists despite preference for standard measures.** Although 59% of the measures come from standard sources--with 52% of all measures coming from HEDIS—the programs are selecting different subsets of these standard measures for use.[3]

4. **Most programs modify a portion of their measures, which also contributes to a lack of alignment.** Even when the programs select the same measures, the programs often modify the traditional specifications for these standard measures. 83% of the measure sets contained at least one modified measure. 23% of the identifiable standardized measures were modified.[4] Two of the programs modified every single measure and six of the programs modified at least 50% of their measures.

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[1] If a measure showed up in multiple measure sets, it was counted once (e.g., breast cancer screening was counted 30 times in the total measures chart since it appeared in 30 different measure sets, but was counted once as a "distinct" measure). If a program used a measure multiple times ("variations on a theme"), it was only counted once (e.g., the Massachusetts PCMH Initiative used three different versions of the tobacco screening measure; it is counted only once as a distinct measure).

[2] Ironically, this measure is no longer NQF-endorsed due to changes in clinical guidelines put forth by national organizations.

[3] Please note that some of the measures included as "standard measures" have been modified by the programs.

[4] In this analysis, if Bailit did not have access to the specifications, but the measure appeared to be standardized through combination of steward and title or NQF#, it was considered to be a standard

5. **With few exceptions, regardless of how we analyzed the data, the programs' measures were not aligned.** Even though the measures used were selected from the same domains, the programs did not select the same measures from within each domain. This suggests that simply specifying the domains from which programs should select measures will not facilitate measure set alignment. Additionally, while one might hypothesize that programs designed for the same type and/or purpose would have more similarities than the full array of studied measure sets, this is not the case. Bailit reviewed four different types of programs (13 patient-centered medical home (PCMH) programs, six Medicaid MCO programs, six "other provider" programs,[5] and three regional collaborative programs) and found that only Medicaid MCO programs shared more, rather than fewer measures, sharing 62% of their measures. However, none of the other types of programs showed much alignment. The "other provider" programs shared the least number of measures, with only 12% shared. Additionally, while one might anticipate that programs developed for payment would be more standardized and be comprised of primarily NQF-endorsed measures, this is not the case. We also looked at the measure sets within two states: California (CA) and Massachusetts (MA) and found that CA has significantly more alignment across its measure sets when compared to MA and the total measures set. This alignment within CA may be due to our sample; three of the seven measure sets were developed by the same organization (Office of the Patient Advocate). However, anecdotally, we have been told that CA has also worked to align its measure sets. While MA has work underway to align its measure sets across the state though the Statewide Quality Committee, currently there is little alignment within the state.

6. **Many programs create their own measures.** 40% of the programs created at least one new measure for use, resulting in 198 homegrown measures. Of these 198 measures, there were 28 measures (14%) for which it was not readily apparent as to why the program created the measures, as these measures appeared to replicate standard measures. Perhaps the programs were unaware of the availability of the standard measures. 41% of the measures were specific to an aspect of a particular program. These measures primarily related to infrastructure, utilization, geographic access and oversight of a program. Since they are specific to the management or structure of a particular program, they are unlikely to become standardized. Approximately 10% of the measures appear to have been designed to give providers additional flexibility and options with regard to the measurement tool or outcome. For example, the Texas program includes a quality of life measure, but allows the provider to select a validated tool to offer its providers flexibility regarding which tool they use. Finally,

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measure. This approach is likely to underestimate the extent of modification and suggests that there is likely to be more modification than represented by this analysis.

[5]The "other provider" category denotes programs that are focused on either paying or reporting performance at the provider level, but are not used for ACO, PCMH or Health Home programs.

approximately 35% of the homegrown measures seem to fill a perceived measurement gap. These measures focused on the areas of care management and coordination, patient self-management and cost.

7. **Most homegrown measures are not innovative.** While we found that most of the innovation in the measure sets came from the homegrown measures, most of the homegrown measures were not particularly innovative. For this analysis, Bailit defined **"innovative"** to describe measures that are not NQF-endorsed and that address an important health care concern that is not addressed in most measure sets (e.g., care management and coordination, cost, end-of-life care, patient self-management, social determinants of health) or address an issue or condition for which few measures are commonly employed (e.g., dementia, dental care, depression and other mental health conditions, maternal health, pain, quality of life, and substance abuse). Innovation is not widespread across measure sets. Only 38% of the programs included innovative measures and most programs only included one or two innovative measures. Only two programs did a significant amount of innovating in measurement:[6] the Massachusetts PCMH Initiative (17 measures) and the Texas Delivery System Reform Incentive Program (17 measures). Bailit also reviewed two additional measure sets from regional collaboratives that were not included in the core analysis to identify whether they would offer more innovation (Minnesota AF4Q and Oregon AF4Q). Oregon did not include any and Minnesota included four innovative measures.

8. **There appears to be a need for new standardized measures in the areas of self-management, cost, and care management and coordination.** Programs tended to focus their innovation efforts in these areas, suggesting a need for new standard measures in these arenas.

Conclusion: The expansion in the number of standardized measures affords state entities and regional collaboratives many more options than were available two decades ago. Programs tend to use these diverse measures to create their sets independently without an eye towards alignment, focusing rather on their particular local, programmatic needs as well as the desires of various constituencies, such as medical specialties. Even those who may seek alignment across measure sets will find few tools available to help facilitate this alignment. This lack of alignment is burdensome to providers who must report large numbers of measures to different programs and meet related accountability expectations and performance incentives. Mixed messages about quality priorities from these various measure sets results in "measures chaos" and makes it difficult for providers to focus their quality improvement efforts. It is also

[6] While we were not able to review the specifications for the Texas measures, some of these innovative measures appear to be measure concepts that do not yet have specifications, rather than actual measures that are ready to be implemented.

frustrating to purchasers and payers who seek to align incentives and market signals across disparate programs and markets.

We anticipate that as states and health systems become more sophisticated in their use of electronic health records and health information exchanges, there will be more opportunities to easily collect outcome-focused, clinical data-based measures and thus increase use of those types of measures over the traditional claims-based measures. Combining this shifting landscape with the national movement to increase the number of providers that are paid for value rather than volume suggests that the proliferation of new measures and new measure sets is only in its infancy. In the absence of a fundamental shift in the way in which new measure sets are created, we should prepare to see the problem of unaligned measures grow exponentially.

Recommendations: In order to address the problem of measures non-alignment, we recommend the following strategies:

1. **Launch a campaign to raise awareness about the current lack of alignment across measure sets, help states and regions interested in developing measure set understand why lack of alignment is problematic and establish the need for a national measures framework.** In the absence of such an initiative, states and regions interested in creating measure sets have worked and are likely to continue working independently without an eye towards alignment at a state, regional or market level.

2. **Communicate with measure stewards to indicate to them when their measures have been frequently modified**, in particular in the cases in which additional detail has been added, removed or changed (i.e., not when the program just chose to report one of the two rates included in the measure). We recommend sharing with the measure stewards the specific types of modifications that have been made.

3. **Develop an interactive database of recommended measures to help establish a national measures framework.** While the criteria for inclusion in this interactive -- preferable online — tool would have to be more clearly defined, we recommend that it consist primarily of robust standardized measures that are used most frequently for each population and domain. We also recommend identifying measures for the areas in which there are currently few, if any, standardized measures (e.g., patient self-management, care management, cost, etc.). In order to be a success, this resource should be marketed to public and private sector organizations involved directly or indirectly in measurement set development and updated regularly (i.e., at least on an annual basis).

4. **Provide technical assistance to states to help them select high-quality measures that both meet their needs and encourage alignment across programs in their region and market.** This assistance could include:
    a. a measures hotline that states, regional collaboratives and engaged stakeholders could call to ask questions about:
        i. the use of the interactive measures tool;
        ii. help selecting appropriate measures; and/or

a. learning collaboratives, blogs, online question boards and/or listservs dedicated to individuals working with measure sets.
b. the creation of benchmarking resources for the recommended measures selected for inclusion in the interactive measures tool. Programs seeking to implement quality measures to evaluate performance often struggle to set appropriate targets in the absence of benchmark data. While NCQA provides this information for its HEDIS measures through its Quality Compass® tool, benchmarks are not available for most other measures. Providing this information for those measures which currently lack benchmarks will provide programs with an important incentive to choose Buying Value measures over other measures.

5. **Acknowledge the areas where measure alignment is potentially not feasible or desirable.** It is important for the developers of measures sets to consider their populations of focus. For example, we would not recommend that a commercial measure set be identical to a Medicaid measures set that is designed to assess performance of long-term support services in a dually eligible (i.e., Medicare and Medicaid-eligible) population. Additionally, we anticipate the programs will continue to use program-specific measures, especially those that are administratively-focused (e.g., the rate of PCMH enrollment).

MAP Ad Hoc Review Process Options

Overarching Issue

HHS has asked MAP to perform ad hoc reviews of measures outside of the usual pre-rulemaking process in exceptional circumstances. The timelines and budgets for these ad hoc reviews are extremely tight, and don't allow time for MAP's typical multi-level review and public comment processes. **How can MAP's workflows be adapted for ad hoc reviews to maintain its relevance and increase its efficiency, while ensuring the integrity of its processes?**

Background

HHS has asked MAP to establish a process beyond its annual pre-rulemaking review to provide input on measures under consideration for rulemaking on an ad hoc basis. As required by the HHS task order, ad hoc reviews are on expedited timelines and must be accomplished within an eight-week period. In addition, ad hoc reviews are limited to two web meetings.

In May 2013, MAP received its first ad hoc request from HHS to review four measures under consideration for two Medicare programs: the Hospital Acquired Conditions Reduction Program and the Inpatient Psychiatric Facility Quality Reporting Program. MAP convened the Hospital Workgroup to consider these four measures during two web meetings, held on June 10 and June 13, 2013. A summary of these meetings was submitted to HHS on June 27, 2013, providing the MAP Hospital Workgroup's findings on the measures under consideration and the key themes that emerged from the discussion.

The accelerated timeline of the ad hoc review did not allow time for public comment, beyond public comment periods during the web meetings, or for review of the Hospital Workgroup's findings by the MAP Coordinating Committee; thus, the summary of workgroup findings was not characterized as MAP recommendations.

Key Questions

Question 1: Under what circumstances should MAP review measures on an ad hoc basis?

> *Considerations*: NQF is contractually obligated to perform up to two ad hoc reviews each year. Ad hoc reviews are opportunities for MAP to provide HHS with timely input from multi-

stakeholder groups and to promote alignment across federal programs, but controversial issues require adequate time and resources for proper consideration.

Recommendation: The MAP Coordinating Committee co-chairs and chair(s) of relevant workgroup(s) will advise NQF on the appropriateness of accepting ad hoc reviews.

Question 2: What is the proper level of MAP Coordinating Committee review to provide HHS with vetted recommendations, while meeting expedited timelines?

Considerations: The NQF Board established a two-tiered review process for MAP recommendations to promote alignment of measurement across settings. During the first two pre-rulemaking cycles, the Coordinating Committee did not revisit most of the workgroup decisions, but instead focused on alignment and topics that raised issues at the workgroup level. Additionally, as MAP has matured, the Coordinating Committee has adopted guidance, such as the Measure Selection Criteria, to provide parameters for workgroup decision making. Empowering the workgroups to make recommendations on individual measures that are not controversial would allow the Coordinating Committee to focus on more strategic issues during its limited meeting time.

Options:

Option 1: The Coordinating Committee will focus on strategic issues, such as alignment, and issues that are controversial at the workgroup level. The workgroups will be empowered to make recommendations to HHS within parameters set by the Coordinating Committee.

Option 2: The Coordinating Committee will reserve the right to make all measure recommendations. Potential approaches to accommodate the accelerated timeframes required by the ad hoc review process include:

- Schedule more frequent meetings of the Coordinating Committee to allow for timely review by the entire committee. The current ad hoc review budget would not support these additional meetings, but future funding could be requested.
- Conduct MAP Coordinating Committee review of ad hoc findings by email. Processes would need to be developed to make business conducted over email transparent to the public.
- Convene small sub-groups of Coordinating Committee members to represent the Coordinating Committee during ad hoc reviews. The small groups would need to be structured to maintain MAP's careful stakeholder balance.

MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal *measure sets* used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 2.3 Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives

Sub-criterion5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Sub-criterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

MAP Approach for Assessing Potential Measure Impact

Background

The Affordable Care Act requires HHS to assess the impact of quality and efficiency measures used in federal healthcare programs, and to provide the findings in a report to Congress every three years. The first such report, released March 2012, was an assessment of Medicare Quality Measures. CMS convened a Technical Expert Panel (TEP) to advise on the content of subsequent reports.

In addition, HHS has requested that MAP provide input to HHS on the potential impact of quality measures under consideration that MAP recommends for future use in federal programs. In collaboration with HHS, MAP will develop a meaningful approach for these assessments, with an understanding that the input will be limited by the information available. Assessment of potential measure impact presents an opportunity for MAP to provide more granular input to HHS that may enhance MAP's influence on HHS' final selection decisions.

The MAP Measure Selection Criteria and Impact Task Force discussed issues related to assessment of potential measure impact during two task force conference calls in July and August, 2013. Key recommendations and related considerations are discussed below.

Why Does MAP Need to Assess Potential Measure Impact?

MAP seeks to achieve quality improvement, transparency, and value in pursuit of the three aims of the National Quality Strategy. As such, MAP identifies health and health care performance gaps and recommends measures for performance measurement program measure sets that provide incentives to close those gaps. During the course of developing its recommendations, MAP has the unique opportunity to predict the extent to which measures under consideration are likely to impact performance in the context of specific programs, and thereby close performance gaps. While the work of the CMS TEP is primarily focused on assessing the prior impact of individual measures and measure sets over time, MAP's ability to provide prospective input on potential impact from a wide range of invested stakeholders can better inform measure selection decisions until more detailed retrospective information is available.

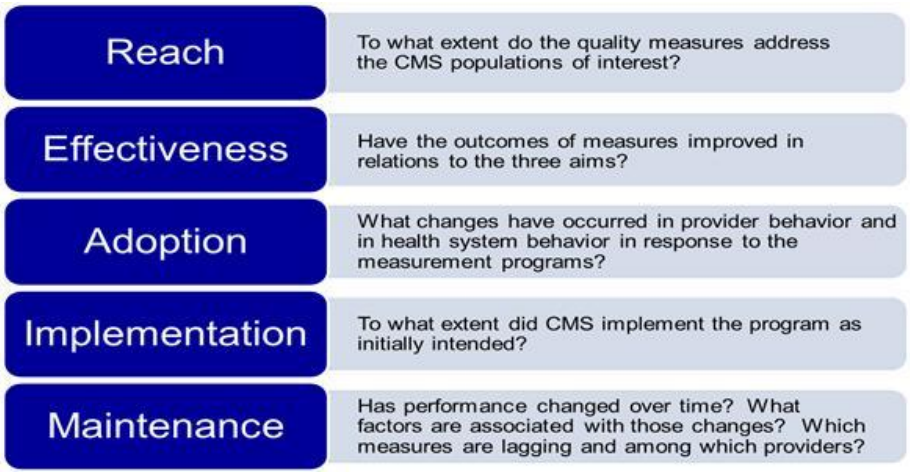
How Can MAP Assess Potential Measure Impact?

MAP is continuously improving its pre-rulemaking process to better identify the most impactful measures for performance measurement program measure sets. The Measure Selection Criteria and Impact Task Force asks the Coordinating Committee to consider the following approach:

1) Clearly define "impact."

- Both CMS and MAP have used the National Quality Strategy as a guiding framework. A simplified definition of impact therefore might be: "The extent to which a measure set addresses the aims and facilitates progress on the priorities of the National Quality Strategy."

- The CMS TEP is using the RE-AIM framework to provide broader context for their input on measure impact assessment, and some of the related questions may also be useful to MAP when considering potential future impact:



2) *Evaluate potential measure impact by the extent to which measures under consideration can help program measure sets meet the MAP Measure Selection Criteria (MSC), particularly through the ability of measures to increase alignment and fill important measure gaps.*
   - **Criterion #1** – Measures receiving NQF-endorsement have been determined to meet or exceed a threshold for importance to measure and report; therefore, measure sets composed entirely or predominantly of NQF-endorsed measures should be expected to have higher impact.
   - **Criterion #2** – The National Quality Strategy (NQS) sets a unified course for improving the quality of health and health care; therefore, measure sets that strongly support the NQS' aims and priorities should have higher impact.
   - **Criterion #3** – The goals and requirements of CMS quality programs are designed around the NQS within various settings, levels of analysis, and populations; therefore, measures that promote filling gaps for these program measure sets should produce higher impact (while also factoring in available RE-AIM assessment information).
   - **Criterion #4** – Choosing the appropriate mix of measure types for a measure set should stimulate improvement by placing more or less emphasis on structures, processes, outcomes, experiences of care and services, and efficiency, depending on the purpose of a program measure set and specific impacts desired.
   - **Criterion #5 –** Measure sets that enable measurement of person-centered care and services can fill important gaps and help to achieve the NQS aim for better care; activated patients are healthier, proactive in working with their providers to coordinate their care and services, and benefit more from the healthcare system.
   - **Criterion #6** – Persistent inequalities exist in healthcare and health outcomes based on race, ethnicity, language, and other defining characteristics; assessing healthcare disparities and cultural competency can help address this important issue by bringing attention to specific areas where inequalities exist.

- **Criterion #7** – Promoting parsimony and alignment in measures sets should provide higher impact relative to the cost associated with measurement by increasing the efficiency of data collection, reducing the effort of maintaining measures, decreasing confusion from interpreting multiple measure sets, and ultimately helping to focus improvement efforts.

3) *Closely integrate with parallel efforts that have related objectives for assessing measure impact.*
    - Strengthen feedback loops as a mechanism to gather input on the practical impact of measures and measure sets in the field. Besides considering information that becomes available as a result of the retrospective analyses, MAP will incorporate input from feedback loops that NQF is establishing via its QPS portfolios, open commenting on measures, and collaboration with various stakeholders.
    - Leverage the roles of George Isham (Measure Selection Criteria and Impact Task Force member, MAP Coordinating Committee co-chair, and CMS impact TEP co-chair); Allen Leavens (NQF MAP staff and CMS impact TEP member); and CMS staff to facilitate closer connections between the work of MAP and the CMS impact assessment TEP (see table below).

Complementary Roles of CMS Technical Expert Panel and MAP in Assessing Impact

	CMS TEP	**MAP**
Perspective	Retrospective evaluation	Prospective evaluation
Composition	Primarily academic and technical experts	Broad multi-stakeholder group with diverse backgrounds
Primary Anticipated Output	Detailed analyses of impact, which may be at the individual measure level	Broad assessment of the potential impact of adding new measures under consideration to measure sets
Cross-Effort Representation	George Isham – TEP co-chair; Allen Leavens – TEP member; CMS staff	George Isham – Coordinating Committee co-chair; Allen Leavens – NQF staff; CMS staff
Funding	CMS contract with HSAG	No separate funding beyond CMS funding of MAP pre-rulemaking activities

NATIONAL QUALITY FORUM

Measure Applications Partnership: Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults

DRAFT FOR PUBLIC COMMENT

September 30, 2013

I. Introduction

The Measure Applications Partnership (MAP) is a multi-stakeholder group of public- and private-sector organizations and experts convened by the National Quality Forum (NQF). The Department of Health and Human Services (HHS) recently engaged MAP to provide input on the Initial Core Set of Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set or Core Set). The MAP Dual Eligible Beneficiaries Workgroup reviewed the Core Set and provided its input to the MAP Coordinating Committee, which will issue final MAP input to HHS (see Appendices A and B for workgroup and committee rosters).

In its review of the measures, MAP identified opportunities to revise and strengthen the Medicaid Adult Core Set. MAP offers a mix of measure-specific and general recommendations to improve the accuracy, breadth, and feasibility of reporting the Medicaid Adult Core Set. This report also includes information that was provided to the workgroup as background to inform its review of the Core Set, specifically an overview of the population of adults enrolled in Medicaid and the purpose and history of the Adult Medicaid Quality Reporting Program.

HHS will use MAP's findings to inform an update of the Medicaid Adult Core Set required by statute to occur in 2014. A MAP Medicaid Task Force will convene in 2014 to provide additional input on future revisions.

II. The Adult Medicaid Population

Since 1965, Medicaid has been an important source of health coverage for low-income adults and children. Following Medicaid expansion under the Affordable Care Act (ACA), enrollment is projected to rise from 15 percent of the country's population in 2010 to 25 percent in 2020.[1] At last count (2009), 62.7 million people were covered by Medicaid, including 30.7 million children, 16.3 million adults, and 15.6 million elderly or disabled individuals.[2]

Average Medicaid spending per enrollee varies sharply by eligibility group. In 2009, average annual payments totaled $2,300 per child, $2,900 per non-elderly adult, $15,840 per disabled enrollee, and $13,150 per elderly enrollee.[3] While non-elderly, non-disabled adults consume relatively fewer resources than individuals who receive long-term supports and services, their healthcare needs can still be significant. In particular, adults' access to high-quality preventive care and chronic disease management can greatly affect lifetime health outcomes.

MAP considered the overall health status of adult Medicaid enrollees and conditions that are common in the population to ensure that measures in the Adult Core Set were appropriately tailored. Overall, it is important to note that approximately one in five adults younger than 65 on Medicaid reports fair or poor physical health; approximately one in seven reports fair or poor mental health.[4,5] In addition, Medicaid plays a dominant role in covering reproductive health services. Nearly two in three adult women on Medicaid are in their reproductive years (19-44) and an estimated 48 percent of births in the U.S. were paid for by Medicaid in 2010.[6] Finally, an estimated 57% of adults covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.[7]

New adult Medicaid enrollees have a slightly different profile, and MAP also considered this in its review. Potentially eligible adults under ACA expansion are projected to have better or equal health status than current enrollees, with lower rates of obesity and depression.[8] However, the prevalence of

other behavioral health conditions may be higher. In addition, 49% of potentially eligible adults report using tobacco and 22% report high or moderate alcohol use.[9] These use rates are significantly higher among new enrollees than current enrollees and underline the importance of addressing these and other modifiable risk factors.

MAP also considered demographic factors and social determinants of health. Adults covered by Medicaid tend to be non-white, unmarried, and to have less than a high school level of education.[10] Medicaid enrollees are affected by disparities in health and healthcare, often facing barriers to accessing needed services.

III. Overview of the Medicaid Adult Core Set Program

Statutory Authority

The Affordable Care Act (ACA, section 1139B) requires that the Secretary of HHS identify and publish for public comment a recommended initial core set of health care quality measures for Medicaid-eligible adults.[11] The statute requires the initial core set to be comprised of "existing adult health care quality measures in use under public and privately sponsored health care coverage arrangements or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time and that may be applicable to Medicaid-eligible adults."[12]

To assess the quality of care for adults enrolled in Medicaid, the law calls for HHS to:

1. Develop a standardized reporting format for the core set of measures;
2. Establish an adult quality measurement program;
3. Issue an annual report by the Secretary on the reporting of adult Medicaid quality of care information and a Report to Congress every three years; and
4. Publish updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures.[13]

Process for Compiling the Initial Core Set of Measures for Medicaid-Eligible Adults

In 2010, the Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), and developed a subcommittee to the National Advisory Council for Healthcare Research and Quality. The subcommittee was charged with considering the health care quality needs of adults ages 18 and older enrolled in Medicaid. Members represented a broad range of experts and stakeholders, including multiple individuals who also serve on MAP.

The subcommittee focused on four dimensions of health care related to adults enrolled in Medicaid: adult health, maternal/reproductive health, complex health care needs, and mental health and substance use. Starting from approximately 1,000 measures drawn from nationally recognized sources, the group deliberated and identified 51 measures for public comment.

Public comments commonly remarked upon the large size of the measure set and suggested that it be aligned with existing reporting programs to reduce data collection and reporting burden. Other, less frequent comments suggested: 1) avoiding measures that require medical record review, 2) using only measures endorsed by NQF, 3) re-examining the appropriateness of some proposed measures, and 4) including measures related to the topics of patient safety and rehabilitation. Additionally, comments

cumulatively suggested that 43 measures be considered for addition to the set, many of which had been previously considered.

Following public comment, CMS considered how to reduce the size of the measure set utilizing five criteria identified based on NQF's endorsement criteria: importance, scientific evidence supporting the measure, scientific soundness of the measure, current use in and alignment with existing Federal programs, and feasibility for state reporting. In January 2012, CMS published the final rule with a total of 26 measures for voluntary use by states as the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid.[14]

State Experience in Collecting the Medicaid Adult Core Set Measures: Adult Medicaid Quality Grants

CMS has identified a three-part goal for this quality reporting program: increasing the number of states reporting Medicaid Adult Core Set measures, increasing the number of measures reported by each state, and increasing the number of states using Core Set measures to drive quality improvement.

To assist in understanding how well the Medicaid Adult Core Set measures and their technical specifications could be collected by states, CMS launched a two-year grant program in December 2012. As part of this grant program, 26 Medicaid agencies are developing staff capacity to collect, report, and analyze data on the Medicaid Adult Core Set. In addition, the grantees are required to conduct two quality improvement projects using measures from the Core Set. States receive technical assistance and analytic support as part of the grant program.

Early feedback from the grantees has provided better understanding of the feasibility of implementing the measures in the Medicaid Adult Core Set. Specific challenges have included reporting physician-level and hospital-level measures at the state level, difficulties with measures that require medical record review, and the need for more detailed and straightforward technical specifications. Grantee feedback will continue to be monitored and shared with MAP for future decision-making.

Future Activities

Voluntary reporting of Medicaid Adult Core Set measure data to CMS is scheduled to begin at the end of 2013.[15] By January 1, 2014, HHS will annually publish recommended changes to the Core Set that reflect the results of the testing, validation, and consensus process for the development of adult health quality measures. By September 30, 2014, HHS will collect, analyze, and make publicly available the information reported by the states as required in section 1139B(d)(1) of the Act.[16] HHS will also include information on adult health quality in a mandated report to Congress, to be published every 3 years in accordance with the statute.

IV. MAP Review of the Medicaid Adult Core Set

MAP considered the current version of the MAP Measure Selection Criteria (MSC) (Appendix C) to evaluate the strength of the Medicaid Adult Core Set. The MSC are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. MAP used the MSC to guide the evaluation of the program measure set and its ability to meet the program goals outlined by CMS.

Table 1 describes the properties of the 26 measures included in the Medicaid Adult Core Set. Some characteristics such as care setting and level of analysis are not mutually exclusive; measures are specified for more than one. Measures may also be in both one or more Federal program(s) and a State Dual Eligible Beneficiaries Integration Demonstration. Overall, the majority of measures in the Medicaid Adult Core Set are NQF-endorsed process measures; are most commonly applied to the ambulatory care setting; can be analyzed for health plans and populations; and align with other public and private programs.

Table 1: Medicaid Adult Core Set Measure Properties

Measure Properties	Measure Sub-Properties	Measure Count (Total n=26)
NQF Endorsement	Endorsed	21
	Not Currently Endorsed	5
Measure Type	Outcome	7
	Process	19
Care Setting	Ambulatory Care	21
	Behavioral Health	4
	Hospital/Acute Care	9
	Post-Acute/Long-Term Care	3
	Other (e.g., Pharmacy)	3
Level of Analysis	Clinician	12
	Facility	3
	Health Plan	17
	Integrated Delivery System	9
	Population	15
Alignment	In Another Federal Program	19
	In a State Duals Integration Demonstration	15
	In one or more of MAP's Families of Measures	12
	In NCQA's HEDIS Program	17

General Recommendations

Application of the MAP MSC generated a series of general recommendations to strengthen the Medicaid Adult Core Set over time. In assessing the Core Set, MAP found that it is adequate to advance CMS' stated goals for the program. MAP judged the Core Set to have a satisfactory number of outcome measures, to give sufficient attention to the three aims and six priorities of the National Quality

Strategy, and to be sensitive to health disparities. The Medicaid Adult Core Set is particularly strong in its alignment with other program sets and its parsimonious number of measures.

MAP's other general recommendations primarily relate to the need for the measure set to evolve in parallel with advances in the field of health care quality measurement and encourage development of new measures in key areas. In selecting measures for the first iteration of the Medicaid Adult Core Set, CMS was limited to those that were currently available for immediate use. As revisions are published and additions are considered, MAP encourages CMS to consult MAP's families of measures for promising measures and measure concepts.

Though several measures in the Medicaid Adult Core Set relate to mental health, they are fairly narrow in scope. Behavioral health conditions are highly prevalent in the Medicaid population and affect both mental and physical wellness. Too often, these conditions are not diagnosed and treated. MAP suggests that development of a composite measure of mental health screening could help address this issue. Such a composite should include a wide variety of conditions, including depression, schizophrenia, and anxiety disorders.

MAP noted an additional gap area related to structural measures of access to care. These are important because of their relationship to health care disparities and providers' and systems' cultural competency. Measuring variability in states' provision of wrap-around support services may illustrate marked differences in beneficiaries' ability to access needed supports. These include enrollment assistance and benefit navigation, specialized services for individuals with disabilities, transportation, and translation services.

Finally, and perhaps most importantly, the field lacks performance measures that evaluate goal-directed, person-centered care and outcomes that matter to individuals enrolled in Medicaid. MAP members remarked on the clinical orientation of the measure set and its inability to gauge fundamental concepts such as functional status and community integration. MAP strongly encourages CMS to pursue development activities in these topic areas.

Measure-Specific Recommendations

Application of the MAP MSC also generated a series of measure-specific recommendations to immediately strengthen the Medicaid Adult Core Set. Several relate to MSC #1 and the general principle that the best available NQF-endorsed measures are strongly preferred for use in program measure sets. For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or possible substitutions as detailed below.

NQF #0031: Breast Cancer Screening

Discussion: Breast Cancer Screening has lost NQF endorsement since the Medicaid Adult Core Set was published. Since that time, the measure steward, the National Committee on Quality Assurance (NCQA), has completed an update of the measure that incorporates new clinical practice guidelines and has included new specifications in the 2014 HEDIS manual. NCQA plans to submit the revised measure at the next endorsement review opportunity offered by NQF.

Recommendation: MAP requires the use of NQF-endorsed measures in program sets, if available, because of their recognized rigor. While this measure is not currently endorsed, MAP supports

continued focus on breast cancer screening. MAP recommends that CMS use the most current version of the measure in the Medicaid Adult Core Set and encourages NCQA to submit the updated measure for NQF endorsement.

NQF #0403: Annual HIV/AIDS Medical Visit

Discussion: Annual HIV/AIDS Medical Visit has lost NQF endorsement since the Medicaid Adult Core Set was published. Endorsement was removed during the measure's most recent maintenance review. The measure steward, NCQA, has no intention to edit and resubmit the measure.

Recommendation: In cases when a measure has lost endorsement and it is not updated or replaced, use of the measure should stop. Such a measure should be replaced in the program set by a superior measure on the same topic. HIV/AIDS is a high-impact condition in the Medicaid population and MAP recommends that CMS consider another NQF-endorsed HIV/AIDS measure as a replacement. MAP strongly supports use of measure #2082: Viral Load Suppression because it is a highly meaningful and regularly collected clinical indicator that is predictive of overall outcomes. This measure is also perceived as relatively less burdensome for data collection because it can be drawn from administrative data. The workgroup also supported #2083: Prescription of HIV Antiretroviral Therapy Regardless of Age as a possible alternative.

NQF #0021: Annual Monitoring for Patients on Persistent Medications

Discussion: Annual Monitoring for Patients on Persistent Medications has lost NQF endorsement since the Medicaid Adult Core Set was published. The steward, NCQA, withdrew this measure from consideration during its most recent maintenance review. NCQA has not yet determined whether they will revise and resubmit the measure.

Recommendation: The measure should be updated or replaced with an endorsed measure on the same topic. Medication management is a vital quality indicator. However, currently endorsed measures tend to focus on single medications (e.g., warfarin) or an older population (65+) and are not as appropriate for a broad-based program like the Medicaid Adult Core Set. MAP recommends that CMS retain the measure in the set for the time being, monitor measure development in this topic area, and update or replace the measures as soon as a suitable alternative is available.

NQF #0039: Flu Shots for Adults Ages 50-64

Discussion: Flu Shots for Adults Ages 50-64 excludes Medicaid enrollees 18-49, a large portion of the Medicaid population. The Centers for Disease Control and Prevention (CDC) recommends that all adults receive annual vaccination against the flu. Moreover, pregnant women, older adults, and people with certain chronic conditions or disabilities are at higher risk of poor outcomes if they become infected.

Recommendation: MAP recommends that the measure be expanded to include all adults. The measure steward, NCQA, has completed an update of the measure that broadens the denominator age group to include all individuals age 18 and older and has included new specifications in the 2014 HEDIS manual. MAP strongly encourages NCQA to submit the new specifications to NQF during the measure's annual update process. MAP further recommends that CMS use the most current, expanded version of the measure in the Medicaid Adult Core Set.

NQF# 1690: Adult Body Mass Index (BMI) Assessment

Discussion: Adult Body Mass Index (BMI) Assessment has not been NQF-endorsed. The steward, NCQA, withdrew this measure from consideration and intends to revise and re-submit the measure for future NQF review.

Recommendation: The measure should be updated or replaced with an endorsed measure on the same topic. Obesity is common in the Medicaid population, and MAP recommends that CMS consider an NQF-endorsed measure as a replacement if NCQA's update is not forthcoming. MAP specifically supports use of measure #0421: Preventive Care and Screening: BMI Screening and Follow-Up, as an alternative. This NQF-endorsed measure complies with the current USPSTF recommendations. It is possible to collect measure #0421 from administrative claims data or electronic medical records, an important consideration for the feasibility of implementing this measure in the Medicaid Adult Core Set.

NQF #1768: Plan All-Cause Readmissions

Discussion: There is not a risk adjustment methodology for the Medicaid population in Plan All-Cause Readmissions. Risk adjustment is necessary to fairly interpret measure results. Without it, one cannot determine if differences in performance are due to overall quality or the characteristics of the denominator population. The health of the adult Medicaid population has been shown to be significantly different than the general population and justifies use of an appropriate risk adjustment methodology.

Recommendation: MAP stressed the importance of risk adjustment for the Medicaid population and strongly supports CMS' planned effort to work with the measure steward to develop a Medicaid-specific methodology. MAP also encourages CMS to consider other potential applications of this work to other measurement programs for the Medicaid population.

NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Discussion: Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) are paired measures; however, only #0648 is included in the Medicaid Adult Core Set. Safe and effective care transitions after discharge from a hospital environment are highly dependent upon many levels of communication. Transition records need to be effectively shared with providers receiving the hand-off as well as individuals being discharged and their families and caregivers. Participants in the review noted that these measures are specified for the facility level of analysis and therefore are more challenging to collect than those designed for populations or health plans. CMS noted that they are aware of the difficulties and view Timely Transmission of Transition Record as a "stretch" measure but want to encourage states to build the relationships with providers that are necessary to collect and report this measure.

Recommendation: CMS should consider adding Transition Record with Specified Elements Received by Discharged Patients to the measure set. Doing so would enhance person-centeredness and may also improve the feasibility of data collection for Timely Transmission of Transition Record. MAP noted that these paired measures do not fully address the important issue of care coordination, however Timely Transmission of Transition Record is the only measure in the Medicaid Adult Core Set that directly assess care coordination, and so it should be preserved.

V. Future Activities

In the coming months, CMS and its technical assistance team will work with participating states to complete the first submission of performance measure data to CMS. This data is scheduled to be made publicly available by September 30, 2014. CMS is also planning to begin measure development activities in 2014, moving one step closer to making new measures available to fill key gaps in the Core Set.

MAP will have the opportunity to conduct a second review of the Medicaid Adult Core Set in mid-2014. NQF and MAP will continue to work closely with CMS and its technical assistance providers to monitor implementation challenges and further opportunities for strengthening the Core Set. At the request of MAP members, NQF will support future deliberations by gathering information on the feasibility of data collection at the state level, monitoring the testing of scientific properties of any measures altered after endorsement, understanding data collection methodologies, and how states are acting on the performance data they collect.

Appendix A: 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	Gwendolen Buhr, MD, MHS, MEd, CMD
America's Essential Hospitals	Steven Counsell, MD
Center for Medicare Advocacy	Alfred J. Chiplin, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
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 Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall, MPP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

Appendix B: 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
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Representative to be determined
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
LeadingAge	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Representative to be determined
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
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)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	John E. Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Representative to be determined

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
National Committee for Quality Assurance	Peggy O'Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Appendix C: MAP Measure Selection Criteria

(Version used at time of Workgroup Review)

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal *measure sets* used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 2.3 Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives

Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Sub-criterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

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NQF Efforts to Promote Affordable Care

The National Quality Forum (NQF) seeks to drive and track progress on the National Quality Strategy (NQS) aims, including affordability. Serving as a neutral convener for public- and private-sector stakeholders, NQF is pursuing aligned affordability measurement and improvement efforts. Specifically, through an integrated approach to its affordability work, NQF will answer the following questions:

1. How do various stakeholders define affordability, and what do they consider most important to measure?
2. What measures are available to assess affordability and should be readily implemented in accountability programs?
3. What are the key methodological challenges to developing and using measures of affordability?

Below is a description of NQF's efforts to address each key question.

Defining Affordability Measurement Priorities through the Lenses of Multiple Stakeholders

Recognizing that affordability is a broad concept that can be interpreted in many ways, the Measure Applications Partnership (MAP) will establish parameters for affordability and develop consensus-based definitions. In conducting this work, MAP will reach out to stakeholders beyond MAP membership to understand the various perspectives of who is responsible for health care costs and what the various stakeholders consider measurement priorities. For example, purchasers have not been fully effective in using their leverage with payers and are increasingly shifting costs to employees, while patients tend to equate higher costs with better quality. Affordability definitions will build on prior NQF work that defined efficiency, resource use, and cost.

With consensus-based, shared definitions for affordability to guide NQF's work, MAP will then define the highest-leverage improvement opportunities, informed by stakeholder perspectives and the major cost drivers across settings and populations (e.g., vulnerable populations, commercially insured, Medicaid, Medicare). The improvement opportunities represent subtopics of measurement needed to comprehensively assess affordability across the health care system. Additionally, NQF will take a deep dive on patient-oriented cost measures, seeking patient input to define the cost measures that are most important to consumers.

Available Affordability Measures and Remaining Gaps

NQF will identify measures to address the high-leverage improvement opportunities through endorsing measures related to affordability and by identifying an Affordability Family of Measures. NQF will continue endorsing measures of cost and resource use: an initial phase focused on total cost, non-condition specific, per capita or per hospitalization episode measures. Upcoming phases will focus on condition-specific per capita, and condition-specific episodes, beginning with cardiovascular conditions,

pulmonary conditions, and diabetes. Additionally, NQF will lay the groundwork for endorsing episode-grouper measures by developing episode-grouper measure evaluation criteria. Calls for measures through the NQF endorsement process and structured environmental scans (with a focus on affordability measures, methods for linking cost and quality measures, and measures that are most important to patients) will elucidate the universe of affordability measures.

With an understanding of the universe of affordability measures, MAP will identify an Affordability Family of Measures—a set of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations. The family of measures will serve to promote alignment across settings by highlighting which measures can be readily applied to existing public- and private-sector programs. Recognizing that several high-leverage improvement opportunities will not be addressed through available measures or cannot be applied to existing programs, MAP will prioritize gaps and determine ways to address implementation barriers.

Guidance on Key Measure Methodological Challenges

While significant advances have been made in measuring progress on the NQS aims of better care and healthier communities, progress in the domain of affordability has been hampered by multiple measure methodological challenges. With funding from the Robert Wood Johnson, NQF will provide guidance on:

- How to best combine cost measures with clinical quality measures to assess efficiency of care;
- Approaches to overcoming technical challenges related to cost measures (e.g., data sources, risk adjustment, attribution); and
- How to integrate patient-oriented cost measures into assessments of efficiency.

MAP will consider how this guidance can be readily applied in the context of existing public- and private-sector programs.