Measure Applications Partnership

Coordinating Committee In-Person Meeting

October 3, 2013

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

- Review uptake of MAP recommendations and MAP Ad Hoc Review experience
- Finalize refinements to the MAP Measure Selection Criteria
- Finalize approach for assessing potential impact of measures under consideration
- Finalize recommendations to HHS on the Adult Medicaid Initial Core Set of Measures
- Review integrated approach to identifying the MAP Affordability Family of Measures
- Review approach for assessing the Health Information Exchange Quality Rating System

Introductions and Disclosures of Interest

Progress toward Alignment

HHS Measure Alignment and the MAP

October 3, 2013

Patrick Conway, MD MSc
Deputy Administrator for Innovation and Quality
Chief Medical Officer

Kate Goodrich, MD MHS
Director, Quality Measurement and Health Assessment Group
Centers for Clinical Standards and Quality (CCSQ)

Objectives

- Describe HHS work to align measures
- Describe how these activities are informed by the important work of the MAP, especially families of measures
- Challenges to the MAP

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Measurement Policy Workgroups

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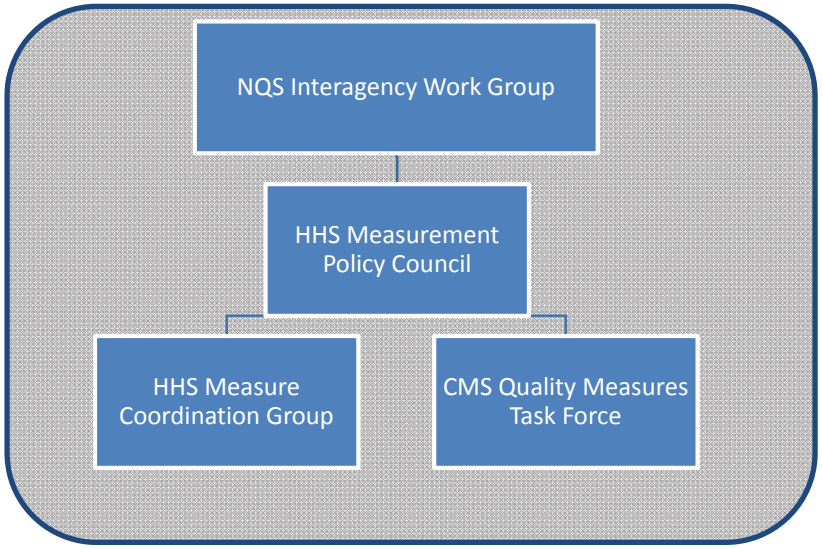
Measurement Policy Work Groups



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CMS Quality Measures Task Force (QMTF)

Charge:

Develop recommendations on CMS measure implementation with the goal of aligning and prioritizing measures across programs and avoidance of duplication or conflict among developing and implemented measures

Goals:

- Establish and operationalize policies for program-specific and CMS-wide measurement development and implementation
- Align and prioritize measures across programs where appropriate
- Coordinate development of new measures across CMS
- Coordinate measure implementation, development and measurement policies with external HHS agencies
- Review and approve all measures for the pre-rulemaking and rulemaking processes

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HHS Measure Policy Council (MPC)

- Assembled in spring 2012 as a sub-group of the HHS National Quality Strategy Group
- Agencies represented: AHRQ, CMS, CDC, ONC, HRSA, IHS, NLM, OASH, SAMHSA, ASPE, ACL
- Cross-Departmental measure alignment on specific topics
- Establishes and operationalizes policies for HHS-wide measure development and implementation

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Alignment Progress To Date

- **Hypertension Control**
  - NQF 0018
  - MU Pipeline: percentage of patients aged 18-85 years with a diagnosis of hypertension whose blood pressure improved during the measurement period
- **Smoking Cessation**
  - NQF 0028
  - Meaningful Use Core Measure 9: Record smoking status for patients 13 years or older
  - CHIPRA composite in development
- **Depression**
  - NQF 0418 (screening with standardized tool and f/u)
  - NQF 0710 (12 month remission defined by PHQ-9 score)
  - NQF 1401 (post partum screen during child wellness visit)

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Alignment Progress To Date

- **Hospital Acquired Infections (HACs)**
  - 9 Partnership for Patients (P4P) topics and associated measures*
- **Care Coordination**
  - Consensus on ONC's "closing the referral loop" as an important measure topic
  - Premature to prospectively align with the ONC measure, as its development is in evolution
- **Patient Experience**
  - Review of CAHPS domain revealed no major alignment issues to date

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Alignment Progress to Date

- **HIV**
  - Viral load suppression
  - PCP Prophylaxis
  - ARV therapy for adults and children
  - Four risky behavior screening measures
  - Pipeline: General population screening
- **Perinatal**
  - Elective Delivery
  - Antenatal Steroids
  - C-section rate for nulliparous singleton vertex
  - Low birth weight < 2500 grams
  - Prenatal and post-partum care

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MPC Ongoing work

- Ensure ongoing connection with the work of the MAP
- In partnership with NQF and MCG, develop consensus on decision rules for categorization of measures
- Continued retrospective and prospective alignment of measures
- Review agency "action plans" for measure alignment quarterly
- Oversee the work of the MCG to coordinate measure development
- Promote transparency of measure development pipeline
- Vehicle for early engagement of Federal stakeholders in the pre-rulemaking process
- Understand how to leverage relevant population surveys, surveillance systems, and other data collection systems to promote alignment

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Measurement Coordination Group

- Operational arm of the MPC
- Development of decision rules for measure categorization
- Development and implementation of a measure development coordination plan
- Operationalize alignment of measures within each agency
- Ad hoc requests from MPC

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MAP, Families of Measures & HHS

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Families of Measures

- MAP reviewed 676 measures for inclusion in the measure families: 55 safety, 60 care coordination, 37 cardiovascular and 13 diabetes.
- Key considerations included:
  - Patient-caregiver engagement is key to improvement
  - Measures should contribute to a push toward evaluating 'systemness' versus silos
  - Preferential view of outcomes measures over process and structural measures, recognizing some of the latter measures are valuable
  - Cost of care is an important consideration when constructing a family
  - NQF-endorsed measures should be preferentially included in families given the evidence base and consensus process behind them
  - Readmissions measurement should be considered as part of a larger care coordination context

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Measure Implementation through HHS and CMS Workgroups

- MAP Families of Measures report presented a new way of organizing measures and served as a guide for MAP's recommendations to HHS about the best available measures for programs across multiple care settings.
- CMS' QMTF and the MPC have found this very helpful in determining how we select measures across programs and settings that relate to one another.
- This work has resulted in "families of measures" becoming part of the common measure lexicon, and encourages us to explicitly identify links between QMs and population based measures

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Measure Implementation through HHS and CMS Workgroups

- MPC and QMTF are working to operationalize and align MAPs recommendations across programs.
- MAP recommendations are explicitly reviewed and considered by QMTF and program leads during rule-making
- MPC and QMTF have adopted the Measures Application Partnership measure selection criteria
- MAP work strongly informs MPC deliberations on core sets of measures

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Challenges to the MAP

- For NQF and MAP, how do focus on the measure science and "leave our organizational interests at the door" in decision-making processes?
- Help us prioritize how we fill gaps (so many gaps – where do we start and who/how are gaps filled?)
- In making recommendations, give explicit consideration to vulnerable populations
- Tiered recommendations and rationale is helpful – will need to continue to refine approach
- For clinicians, what measures could or should be reported by ALL clinicians? And/Or should there be core common sets for each major specialty?
- What are some "leading edge" measures or concepts that should be considered in CMS programs or Innovation center models?

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Questions?

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

An Analysis of 48 State and Regional Measure Sets, Presentation

Kate Reinhalter Bazinsky
Michael Bailit
September 10, 2013

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Finding #1: Many state/regional performance measures for providers are in use today

- In total, we identified **1367** measures across the 48 measure sets
  - This is counting the measures as NQF counts them, or if the measure was not NQF-endorsed, as the program counts them
- We identified **509** distinct measures
  - If a measure showed up in multiple measure sets, we only counted it once
  - If a program used a measure multiple times (i.e., variations on a theme) we also only counted it once
- We excluded 53 additional hospital measures from the analysis.

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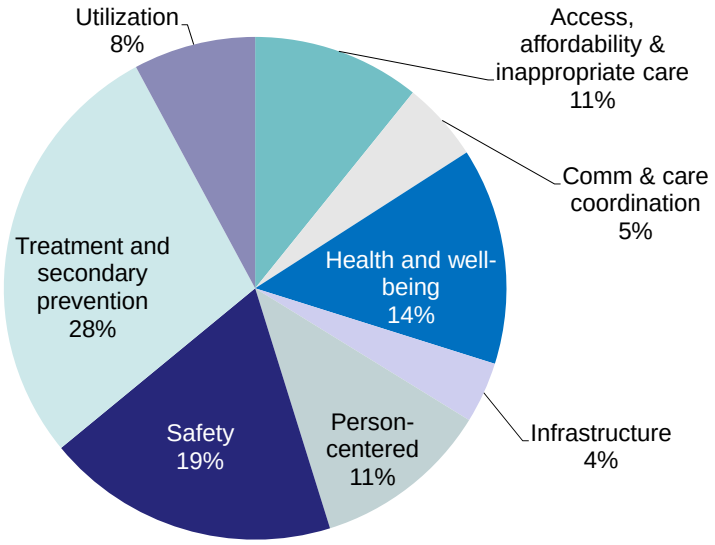
Programs use measures across all of the domains



Distinct measures by domain
n = 509

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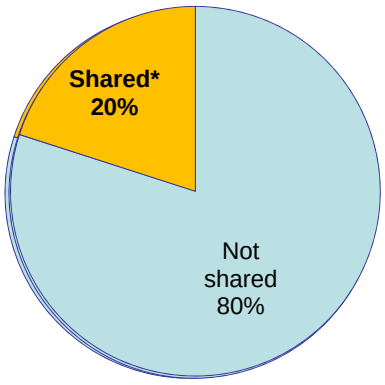
80% of Measures Appear in Only One of the 48 State Measure Sets



Number of distinct measures shared by multiple measure sets
n = 509

- Programs have very few measures in common or "sharing" across the measure sets
- Of the 1367 measures, 509 were "distinct" measures
- Only 20% of these distinct measures were used by more than one program

* By "shared," we mean that the programs have measures in common with one another, and not that programs are working together.

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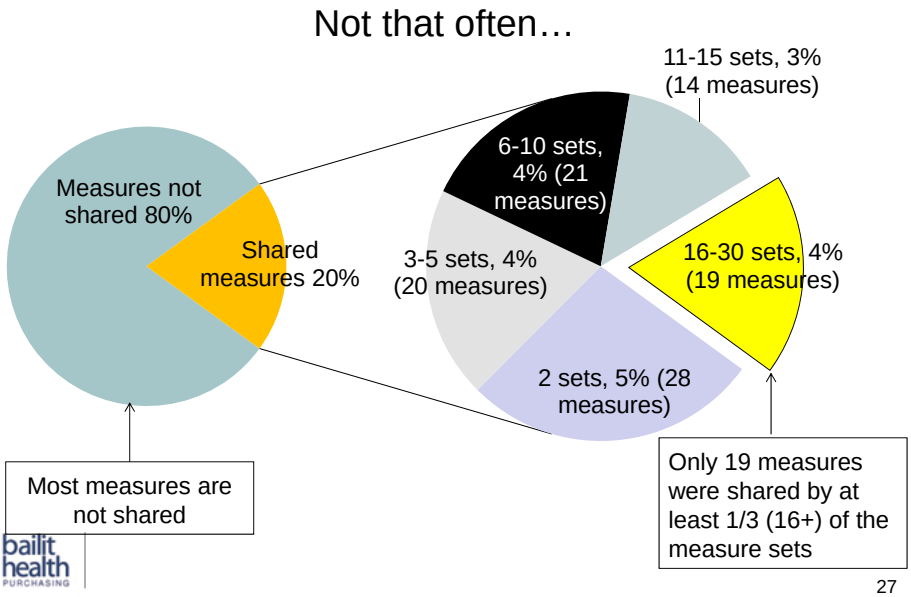
How often are the "shared measures" shared?



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Finding #4: Regardless of how we cut the data, the programs were not aligned

- We conducted multiple analyses and found non-alignment persisted across:
  - Program types
  - Program purposes
  - Domains, and
  - A review of sets within CA and MA
- The only program type that showed alignment was the Medicaid MCOs
  - 62% of their measures were shared
  - Only 3 measures out of 42 measures were not HEDIS measures
- California also showed more alignment than usual
  - This may be due to state efforts or to the fact that three of the seven CA measure sets were created by the same entity.

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Finding #5: Even shared measures aren't always the same - the problem of modification!

- Most state programs modify measures
- 23% of the identifiable standardized measures were modified (237/1051)
- 40 of the 48 measure sets modified at least one measure
- Two programs modified *every* single measure
  1. RI PCMH
  2. UT Department of Health
- Six programs modified at least 50% of their measures
  1. CA Medi-Cal Managed Care Specialty Plans (67%)
  2. WA PCMH (67%)
  3. MA PCMH (56%)
  4. PA Chronic Care Initiative (56%)
  5. OR Coordinated Care Organizations (53%)
  6. WI Regional Collaborative (51%)

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Why do organizations modify measures?

- To tailor the measure to a specific program
  - If a program is focused on a subpopulation, then the program may alter the measure to apply it to the population of interest
- To facilitate implementation
  - Due to limitations in data capabilities, programs may choose to modify the source of measures so they can collect them without changing IT systems
- To obtain buy-in and consensus on a measure
  - Sometimes providers have strong opinions about the particular CPT codes that should be included in a measure in order to make it more consistent with their experiences. In order to get consensus on the measure, the organization may agree to modify the specifications.
  - Sometimes providers are anxious about being evaluated on particular measures and request changes that they believe reflect best practice

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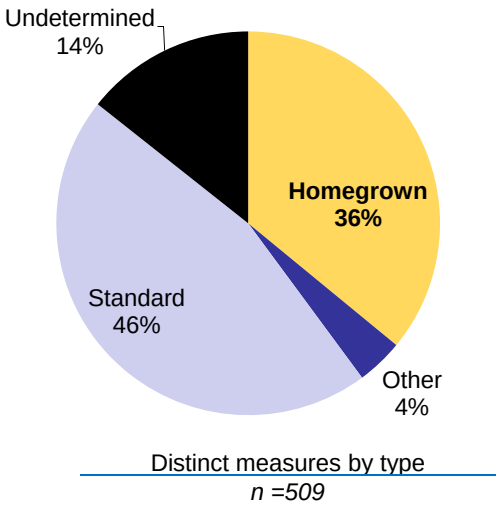
Finding #6: Many programs create homegrown measures



Distinct measures by type
n =509

What are "homegrown" measures?

Homegrown measures are measures that were indicated on the source document as having been created by the developer of the measure set.

If a measure was not clearly attributed to the developer, the source was considered to be "undetermined" rather than "homegrown."

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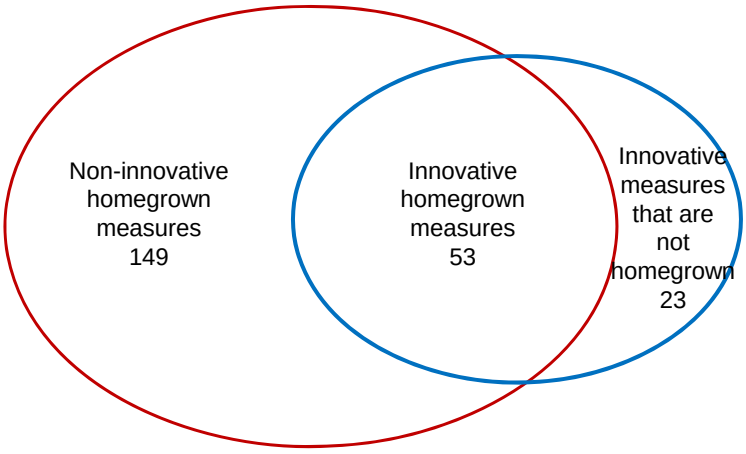
Finding #7: Most homegrown measures are not innovative



But most innovative measures are homegrown

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Note: The numbers on this slide vary slightly from the others since we have added four additional homegrown innovative measures from MN AF4Q.

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Conclusions

- **Bottom line:** Measures sets appear to be developed independently without an eye towards alignment with other sets.
- The diversity in measures allows states and regions interested in creating measure sets to select measures that they believe best meet their local needs. Even the few who seek to create alignment struggle due to a paucity of tools to facilitate such alignment.
- The result is "measure chaos" for providers subject to multiple measure sets and related accountability expectations and performance incentives. Mixed signals make it difficult for providers to focus their quality improvement efforts.

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This is only the beginning…

- 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 clinical data-based measures and thus increase selection 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.

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A call to action

- 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 measure sets grow significantly.

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Recommendations

1. Launch a campaign to raise awareness about the current lack of alignment across measure sets and the need for a national measures framework.
   - help states and regions interested in creating measure sets understand why lack of alignment is problematic
2. Communicate with measure stewards to indicate to them when their measures have been frequently modified and why this is problematic.
   - in particular in the cases in which additional detail has been added, removed or changed
3. Develop an interactive database of recommended measures to establish a national measures framework.
   - consisting primarily of the standardized measures that are used most frequently for each population and domain
   - selecting and/or defining measures for the areas in which there is currently a paucity of standardized measures

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Recommendations (cont'd)

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 measures hotline
   - learning collaboratives and online question boards, blogs and/or listservs
   - benchmarking resources for the recommended measures selected for inclusion in the interactive measures tool.
5. Acknowledge the areas where measure alignment is potentially not feasible or desirable.
   - different populations of focus
   - program-specific measures

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IOM Workshop and Consensus Study of Triple Aim Core Measures

George Isham, M.D., M.S
Senior Advisor
HealthPartners

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IOM Rules -

Prevent me, as a member of the committee, from discussing or commenting publicly on the committee's deliberations. So I won't discuss or comment. My remarks will be limited to providing the publicly available information on the committee's work that I obtained from the IOM website (September 24, 2013) and is provided for the information of the MAP.

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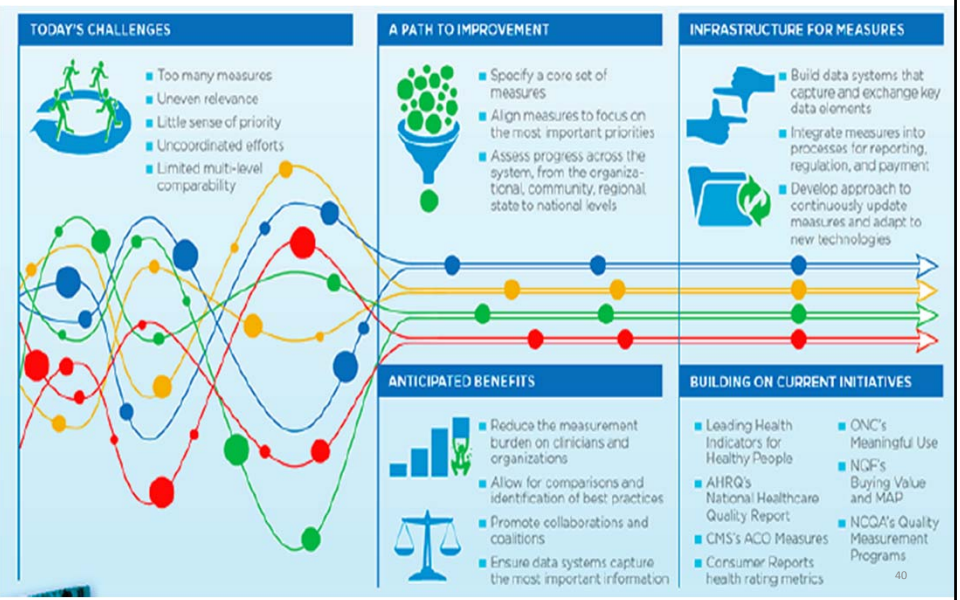
Counting What Counts: Measuring Progress Toward Better Health at Lower Cost - IOM Workshop Report, Dec. 2012



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Committee on Core Metrics for Better Health at Lower Cost

The Committee on Core Metrics for Better Health at Lower Cost will conduct a study and prepare a report directed at exploring measurement of individual and population health outcomes and costs, identifying fragilities and gaps in available systems, and considering approaches and priorities for developing the measures necessary for a continuously learning and improving health system.*

*http://www.iom.edu/Activities/Quality/CoreMetricsForBetterHealth.aspx

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The Committee will:

1. Consider candidate measures suggested as reliable and representative reflections of health status, care quality, people's engagement and experience, and care costs for individuals and populations;
2. Identify current reporting requirements related to progress in health status, health care access and quality, people's engagement and experience, costs of health care, and public health;
3. Identify data systems currently used to monitor progress on these parameters at national, state, local, organizational, and individual levels;
4. Establish criteria to guide the development and selection of the measures most important to guide current and future-oriented action;*

*http://www.iom.edu/Activities/Quality/CoreMetricsForBetterHealth.aspx

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The Committee will (2):

5. Propose a basic, minimum slate of core metrics for use as sentinel indices of performance at various levels with respect to the key elements of health and health care progress: culture (patient/family/citizen-driven); quality (safety and effectiveness-focused); cost (efficiency-oriented); and health (vision-enabling);
6. Indicate how these core indices should relate to, inform, and enhance the development, use, and reporting on more detailed measures tailored to various specific conditions and circumstances;
7. Identify needs, opportunities, and priorities for developing and maintaining the measurement capacity necessary for optimal use of the proposed core metrics; and
8. Recommend an approach and governance options for continuously refining and improving the relevance and utility of the metrics over time and at all levels.*

*http://www.iom.edu/Activities/Quality/CoreMetricsForBetterHealth.aspx

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Expected Delivery Date*

- The report is expected to be issued in the Fall of 2014.

*http://www.iom.edu/Activities/Quality/CoreMetricsForBetterHealth.aspx

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Uptake of MAP Recommendations by CMS; First Ad Hoc Review Experience

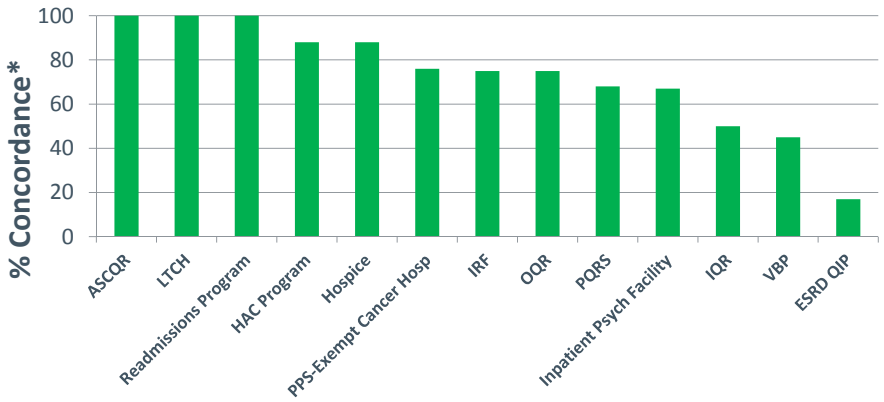
CMS Uptake of MAP 2013 Pre-Rulemaking Recommendations

Uptake of MAP Recommendations in 2013 HHS Proposed Rules

Findings

- MAP was mentioned frequently in proposed rules.
- The vast majority of measures that were not supported by MAP were not proposed by HHS, yielding high concordance (**138/155 = 89%**).
  - The primary source of discordance was HHS proposal of specialty-specific measures for PQRS that were not NQF-endorsed.
- Lower concordance (**61/140 = 44%**) was observed between HHS-proposed measure use and measures that MAP had supported.
  - However, HHS had provided many more measures for MAP to consider than were planned for use.
- A notable number (**27/81= 33%**) of previously finalized measures that MAP had recommended for phased removal were proposed for removal.
- MAP supported the direction of a large number of measures, a subset of which were proposed by HHS (**34/173 = 20%**).

Uptake of MAP Recommendations in 2013 HHS Proposed Rules



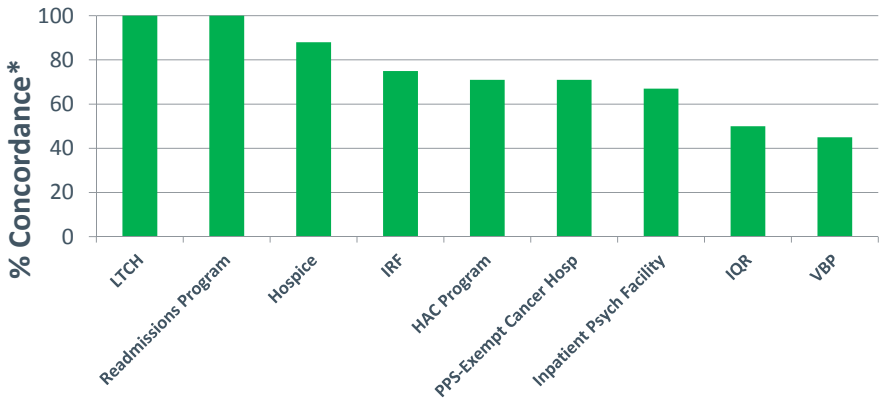
*** % Concordance includes only measures that MAP either did not support or fully supported.**

Uptake of MAP Recommendations in 2013 HHS Final Rules

Findings to Date

- MAP recommendations continue to be cited often within HHS final rules.
- Concordance between HHS final rules released thus far and MAP recommendations has been very similar to what was observed with the corresponding proposed rules:
  - Among measures under consideration that were not supported by MAP, 14/16 (88%) were not finalized by HHS.
  - Among measures under consideration supported by MAP, 38/46 (83%) were finalized.

Uptake of MAP Recommendations in 2013 HHS Final Rules to Date



*** % Concordance includes only measures that MAP either did not support or fully supported.**

Uptake of MAP Recommendations in 2013 HHS Rules

Summary

- Overall, strong concordance continues to be observed between HHS and MAP on measures that should not be used in Federal programs.
  - However, critical program-specific measure needs sometimes lead HHS to use non-endorsed measures that were not supported by MAP.
- Lower concordance is being seen between HHS-proposed and MAP-supported measures, largely due to HHS providing MAP more measures to consider than were actually planned for near-term implementation.
  - HHS has indicated intent to provide MAP a more targeted set of measures to consider going forward.
- Remaining 2013 HHS final rules will be assessed upon release.

MAP Ad Hoc Review Process

MAP Ad Hoc Review Process

- HHS has asked MAP to establish a process outside of the annual pre-rulemaking review to provide input on measures on an ad hoc basis.
- Ad hoc reviews are on expedited timelines and must be accomplished within an eight-week period.
- Ad hoc reviews are limited to two web meetings.

MAP Ad Hoc Review Process

- In May 2013, MAP received its first ad hoc review request from HHS:
  - One measure for the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).
  - Three measures for the HAC Reduction Program.
- MAP convened the Hospital Workgroup through two web meetings (June 10 and June 13) to consider the measures.
- Meeting summary was delivered to HHS on June 27, providing the Hospital Workgroup's findings.
- The accelerated timeline did not allow for public comment, beyond public comment periods during the web meetings, or for review of the findings by the Coordinating Committee.
  - Summary of workgroup findings was not characterized as MAP recommendations.

MAP Ad Hoc Review Process: Questions for the Coordinating Committee

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

- Considerations:
  - MAP is contractually obligated to perform up to two ad hoc reviews each year.
  - Opportunities to provide timely multi-stakeholder input and promote alignment across federal programs.
  - Controversial issues require adequate time and resources for proper consideration.
- Recommendation:
  - Coordinating Committee co-chairs and chair(s) of relevant workgroup(s) will advise on the appropriateness of accepting ad hoc reviews.

MAP Ad Hoc Review Process: Questions for the Coordinating Committee

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

- Considerations:
  - During pre-rulemaking, the Coordinating Committee has not revisited most workgroup decisions, but instead has focused on topics that have raised issues at the workgroup level.
  - 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.

MAP Ad Hoc Review Process: Questions for the Coordinating Committee

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

Options:

- Option 1: Coordinating Committee should focus on strategic issues and issues that are controversial at the workgroup level. The workgroups should be empowered to make recommendations to HHS within parameters set by the Coordinating Committee.
- Option 2: Coordinating Committee reserves 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 Coordinating Committee meetings to allow for timely review by the entire committee.
  - Conduct review of ad hoc findings by Coordinating Committee email exchange.
  - Convene small sub-groups of Coordinating Committee members to represent the Coordinating Committee during ad hoc reviews.

Finalize Refinements to the MAP Measure Selection Criteria

MAP Measure Selection Criteria and Impact Task Force

Charge

- Advise the Coordinating Committee about potential refinements to the MAP Measure Selection Criteria (MSC) to optimize their overall utility, with particular emphasis on integrating key elements of the Hospital and Clinician Guiding Principles developed during 2012-13 pre-rulemaking.
- Respond to HHS' request that MAP assess the potential impact of including measures under consideration in program measure sets.

MAP Measure Selection Criteria

Background

- MAP initially developed the Measure Selection Criteria (MSC) prior to the first round of pre-rulemaking activities in 2011, primarily to guide decisions on recommendations for measure use in federal programs.
- The MSC were designed to help determine if a given group of measures demonstrated the characteristics of an "ideal" program measure set.
- The MAP Strategic Plan calls for continual evolution of the MSC; MAP members have recognized the need to:
  - Apply lessons learned from the past two years.
  - Integrate the Guiding Principles developed by the Clinician and Hospital Workgroups during the 2012-13 pre-rulemaking cycle.

MAP Measure Selection Criteria Revision Process

Initial MSC revisions based on Guiding Principles and other MAP input

Draft MSC revision #1

MSC and Impact Task Force Teleconference #1 – July 31, 2013

Draft MSC revision #2

MSC and Impact Task Force Teleconference #2 – August 21, 2013

Draft MSC revision #3

Coordinating Committee September 11 Web Meeting and October 4 In-Person Meeting

MSC final revisions

Revised Measure Selection Criteria Due to HHS by October 31, 2013

Proposed Revisions to the Measure Selection Criteria

Overarching Changes

- Added a preamble to emphasize that the criteria are meant as guidance rather than rules; application should be to *measure sets,* not individual measures; and focus should be placed on filling important measure gaps and promoting alignment.
- More consistent use of terminology and formatting.
- Removed extraneous content, including the "Response Option" rating scales for each criterion or sub-criterion.

Proposed Revisions to Measure Selection Criterion #1

Revised Criterion 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.

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

Proposed Revisions to Measure Selection Criterion #1

Rationale for Proposed Changes to Criterion 1

- While some flexibility in the short-term is reasonable to meet program needs, the bar should be raised over time.
- Revised language prioritizes endorsed measures, while allowing for practical program-specific goals.

Proposed Revisions to Measure Selection Criterion #2

Revised Criterion 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

Proposed Revisions to Measure Selection Criterion #2

Rationale for Proposed Changes to Criterion 2

- Incorporates the three aims of the National Quality Strategy (NQS); not every measure precisely matches the NQS priorities.

Proposed Revisions to Measure Selection Criterion #3

Criterion 3. – Removed from Measure Selection Criteria

Rationale for Removal:

- Needed to address "high-leverage opportunities," in addition to high-impact conditions.
- Phrasing of the example populations was too CMS-focused and needed to be broadened.
- Once these changes were made, the language was redundant with other criteria, such as Criteria 2 and 4.

Proposed Revisions to Measure Selection Criterion #4

Revised Criterion 3. (formerly Criterion 4)

- 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

Proposed Revisions to Measure Selection Criterion #4

Rationale for Proposed Changes to Criterion 4

- Revised to reflect the Clinician and Hospital Workgroup Guiding Principles.
- Language added to account for eMeasures.
- "Unintended consequences" language modified to make it meaningful and realistic in the context of MAP's role.

Proposed Revisions to Measure Selection Criterion #5

Revised Criterion 4. (formerly Criterion 5)

- 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

Proposed Revisions to Measure Selection Criterion #5

Rationale for Proposed Changes to Criterion 5

- Language tightened to focus on the primary objective of the criterion – selecting an appropriate mix of measures for the specific program for which they are being considered.
  - Balance between outcome measures and process measures linked to outcomes.
- A suggestion was made at the Coordinating Committee web meeting to modify or add wording in revised sub-criterion 4.2 to address outcomes important to patients and their families.

Proposed Revisions to Measure Selection Criterion #6

Revised Criterion 5. (formerly Criterion 6)

- 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

Proposed Revisions to Measure Selection Criterion #6

Rationale for Proposed Changes to Criterion 6

- Language modified to account for the long-term care perspective (i.e., addition of "services" terminology).
- Language modified to create more specific and descriptive sub-criteria about what "person-centered care and services" means.

Proposed Revisions to Measure Selection Criterion #7

Revised Criterion 6. (formerly Criterion 7)

- Program measure set includes consideration 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

Proposed Revisions to Measure Selection Criterion #7

Rationale for Proposed Changes to Criterion 7

- Revised language addresses the issue of discrimination within a measurable framing (i.e., "cultural competency").

Proposed Revisions to Measure Selection Criterion #8

Revised Criterion 7. (formerly Criterion 8)

- 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)

Proposed Revisions to Measure Selection Criterion #8

Rationale for Proposed Changes to Criterion 8

- Revised language calls out alignment (e.g., between programs and measure sets) as a significant part of MAP's goal to be parsimonious in selecting measures.

Opportunity for Public Comment

Finalize Approach for Assessing Potential Impact of Measures Under Consideration

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.
- HHS has requested that MAP provide input on the potential impact of quality measures under consideration that MAP recommends for future use in federal programs.

Assessing Potential Measure Impact

Why Assess Potential Measure Impact

1. MAP seeks to achieve quality improvement, transparency, and value in pursuit of the National Quality Strategy's three aims.
2. MAP identifies performance gaps and recommends measures for program measure sets that provide incentives to fill those gaps.
3. **MAP must predict the extent to which measures are likely to impact performance in particular programs and thereby close the identified performance gaps (assessing impact).**
4. MAP needs feedback about its progress on closing gaps.

Assessing Potential Measure Impact

How to Assess Potential Measure Impact

1. Clearly define "impact."
   - Use NQS as a guiding framework.
   - Use RE-AIM Framework.

Reach	To what extent do the quality measures address the CMS populations of interest?
Effectiveness	Have the outcomes of measures improved in relations to the three aims?
Adoption	What changes have occurred in provider behavior and in health system behavior in response to the measurement programs?
Implementation	To what extent did CMS implement the program as initially intended?
Maintenance	Has performance changed over time? What factors are associated with those changes? Which measures are lagging and among which providers?

Assessing Potential Measure Impact

How to Assess Potential Measure Impact

2. Examine the extent to which measures under consideration can help program measure sets meet the MAP Measure Selection Criteria (MSC), particularly through **increasing measure alignment** and **closing priority performance gaps.**

Assessing Potential Measure Impact

Similarities between RE-AIM and the MSC:

RE-AIM	Examples of related MSC components
Reach	**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)
Effectiveness	**Criterion 2:** Program measure set adequately addresses each of the National Quality Strategy's three aims
Adoption	**Sub-criterion 7.2:** Program measure set places strong emphasis on measures that can be used across multiple programs or applications
Implementation	**Sub-criterion 7.1:** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)
Maintenance	**Sub-criterion 3.4:** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program. **Sub-criterion 5.3:** Measure set enables assessment of the person's care and services across providers, settings, and time

Assessing Potential Measure Impact

How to Assess Potential Measure Impact

3. Closely integrate with parallel efforts that have related objectives for assessing measure impact.
   - CMS Technical Expert Panel.
   - Strengthened feedback loops:
     - Using QPS portfolios.
     - Open commenting on measures.
     - Reaching out to measure developers and other stakeholders.
     - Continuing to update the MSC based on results of ongoing retrospective analyses and evaluations.

Complementary Roles of CMS Technical Expert Panel and MAP Assessment of Measure 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

Review Continuing Efforts of MAP Dual Eligible Beneficiaries Workgroup

Previous and Future Publications

Dec. 2012

Interim Report

Identified an "Evolving Core Set" of Measures for Dual Eligible Beneficiaries

Explored quality issues, potential measures, and measure gaps for high-need subpopulations of medically complex older adults and adults 18-65 with physical disabilities

May 2013

Memo

Explored quality issues, measures, and measure gaps for high-need subpopulations of individuals with behavioral and cognitive conditions

Developed a draft family of measures for dual eligible beneficiaries (*Coordinating Committee approval needed*)

Future Work in 2014

Interim Report Feb. 2014

Final Report Aug. 2014

Continue to explore quality issues and measurement applications related to vulnerable beneficiaries

Create feedback loop to explore alignment across programs

Revise family of measures annually

Properties of the Family of Measures for Dual Eligible Beneficiaries

Measure Properties	Measure Sub-Properties	Measure Count (Total n=55)
NQF Endorsement	Endorsed	51
	Submitted	4
	Not Endorsed	0
Measure Type	Outcome	11
	Process	38
	Structure	1
	Composite	5
Additional Properties	Disparities Sensitive	12
	High-Impact Condition	12
	Patient Reported Outcome	8
	Included in a Federal Program	34
	Included in a State Duals Integration Demonstration	19

Family of Measures for Dual Eligible Beneficiaries

NQF Number and Status	Measure Name
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
0007 Endorsed	NCQA Supplemental Items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)
0008 Endorsed	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
0018 Endorsed	Controlling High Blood Pressure
0022 Endorsed	Use of High Risk Medications in the Elderly
0027 Endorsed	Medical Assistance with Smoking and Tobacco Use Cessation
0028 Endorsed	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0032 Endorsed	Cervical Cancer Screening
0034 Endorsed	Colorectal Cancer Screening
0043 Endorsed	Pneumonia Vaccination Status for Older Adults
0097 Endorsed	Medication Reconciliation
0101 Endorsed	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
0105 Endorsed	Antidepressant Medication Management (AMM)
0111 Endorsed	Bipolar Disorder: Appraisal for Risk of Suicide
0176 Endorsed	Improvement in Management of Oral Medications
0201 Endorsed	Pressure Ulcer Prevalence (hospital acquired)
0202 Endorsed	Falls with Injury
0228 Endorsed	3-Item Care Transition Measure (CTM-3)
0326 Endorsed	Advance Care Plan
0418 Submitted	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
0419 Endorsed	Documentation of Current Medications in the Medical Record

NQF Number and Status	Measure Name
0420 Endorsed	Pain Assessment and Follow-Up
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
0486 Endorsed	Adoption of Medication e-Prescribing
0553 Endorsed	Care for Older Adults – Medication Review
0554 Endorsed	Medication Reconciliation Post-Discharge
0557 Submitted	HBIPS-6 Post Discharge Continuing Care Plan Created
0558 Submitted	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge
0573 Endorsed	HIV Screening: Members at High Risk of HIV
0576 Endorsed	Follow-Up after Hospitalization for Mental Illness
0640 Endorsed	HBIPS-2 Hours of Physical Restraint Use
0641 Endorsed	HBIPS-3 Hours of Seclusion Use
0646 Endorsed	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0648 Endorsed	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0649 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care)
0674 Endorsed	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
0682 Endorsed	Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)

NQF Number and Status	Measure Name
0692 Endorsed	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
0709 Endorsed	Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year
0710 Endorsed	Depression Remission at Twelve Months
0712 Endorsed	Depression Utilization of the PHQ-9 Tool
0729 Endorsed	Optimal Diabetes Care
1626 Endorsed	Patients Admitted to ICU Who Have Care Preferences Documented
1659 Endorsed	Influenza Immunization
1768 Endorsed	Plan All-Cause Readmissions
1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
1902 Endorsed	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
1909 Endorsed	Medical Home System Survey (MHSS)
1927 Endorsed	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
1932 Endorsed	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (SSD)
2091 Endorsed	Persistent Indicators of Dementia without a Diagnosis—Long Stay
2092 Endorsed	Persistent Indicators of Dementia without a Diagnosis—Short Stay
2111 Endorsed	Antipsychotic Use in Persons with Dementia
2152 Submitted	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

"Areas for Action" by HHS and Stakeholders

In its July 2013 memo, the workgroup recommended:

1. Moving forward with exploring the feasibility of making MAP's recommended modifications to the measures for which the federal government is responsible.
2. Engaging measure developers beyond HHS in creating and publishing a plan to address measurement gaps and making funding available to do so.
3. Aligning quality measurement and reporting requirements across programs that serve the dual-eligible population.
4. Pursuing research activities to support new measure development in difficult areas (e.g., social determinants of health, quality of life, "system-ness") and explore promising new methodologies for measurement.

Upcoming Work

- Under a new contract with HHS, MAP and the Duals Workgroup will:
  - Explore issues related to high-need beneficiaries:
    - Measurement of quality of life.
    - Coordination of primary care and behavioral health care.
    - Beneficiary/caregiver engagement, preference, and activation.
  - Create a feedback loop to document measure use by states and health plans serving dual eligible beneficiaries and to reveal opportunities for alignment.
  - Refine family of measures annually based on progress.

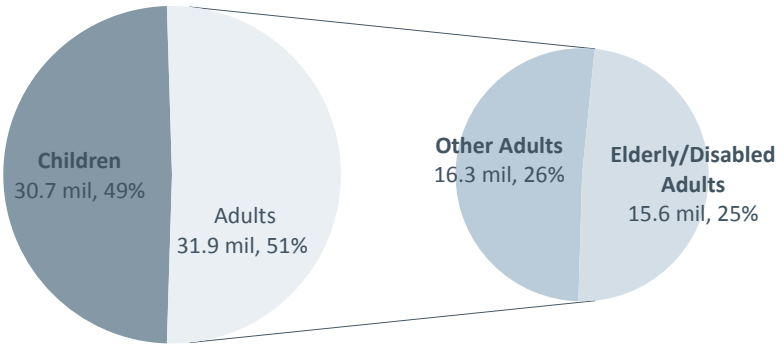
Discussion

- Do Coordinating Committee members have comments or questions related to the family of measures or the "areas for action" recommended in the July memo?
- A November web meeting will explore measurement of "quality of life." Are Coordinating Committee members aware of best practices or progress in this area?
- How can MAP's body of work on vulnerable beneficiaries be better incorporated into pre-rulemaking deliberations?

Finalize Recommendations to HHS on the Adult Medicaid Initial Core Set of Measures

Expedited Review of the Medicaid Adult Core Set

Medicaid Enrollees
(2009, in millions)



Since 1965, Medicaid has been the source of health coverage for low-income adults and children**. Expansion under ACA is projected to enroll an additional 10 million adults.**

Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on the Nation's Health Coverage Program for Low-Income People.* March 2013.

Health Status of Current Adult Medicaid Enrollees

Adult enrollees under 65 have significant health conditions and risks.

- Approximately one in five adults on Medicaid reports being in fair or poor physical health.
- Approximately one in seven adults on Medicaid reports fair or poor mental health.
- An estimated 57% of adults ages 21-64 covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.
- Nearly two of three adult women on Medicaid are in their reproductive years (19-44).
  - An estimated 48 percent of births were covered by Medicaid in 2010.

Kaiser Family Foundation: Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured, June 2009.
Government Office on Accountability: Study on Medicaid Preventive Services, August 2009.

Authority Under the Affordable Care Act

ACA requires that the Secretary of HHS identify and publish a recommended initial core set of quality measures for Medicaid-eligible adults. 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 information; and
4. Publish updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures.

CMS' Goals for Medicaid Adult Core Set and Experiences to Date

The three-part goal for the Medicaid Adult Core Set is to continually increase:

1. Number of states reporting Core Set measures.
2. Number of measures reported by each state.
3. Number of states using Core Set measures to drive quality improvement.

Reporting is voluntary and is just ramping up. State grantees' experiences are providing insight into the feasibility of reporting Core Set measures.

CMS' Future Direction/Next Steps

- MAP's input, due October 15, will be used to inform CMS' recommendations to strengthen the Core Set and in targeting measure development.
- Updates to the Core Set planned to be released via State health official letter in January 2014.
- CMS required to publicly report state data.
  - Report to Congress every three years (beginning January 2014).
  - Annual Secretary's Report (beginning September 30, 2014).
- Measure development in targeted areas projected to begin in FFY2014.

Medicaid Adult Core Set Measures

NQF #	Measure Name	Measure Steward
0039	Flu Shots for Adults Ages 50-64	NCQA
n/a	Adult BMI Assessment	NCQA
0031	Breast Cancer Screening	NCQA
0032	Cervical Cancer Screening	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
0418	Screening for Clinical Depression and Follow-Up Plan	CMS
1768	Plan All-Cause Readmission	NCQA
0272	PQI 01: Diabetes, Short-Term Complications Admission Rate	AHRQ
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	AHRQ
0277	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ
0283	PQI 15: Adult Asthma Admission Rate	AHRQ
0033	Chlamydia Screening in Women Ages 21-24	NCQA

NQF #	Measure Name	Measure Steward
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0469	PC–01: Elective Delivery	Joint Commission
0476	PC–03 Antenatal Steroids	Joint Commission
0403	Annual HIV/AIDS Medical Visit	NCQA
0018	Controlling High Blood Pressure	NCQA
0063	Comprehensive Diabetes Care: LDL–C Screening	NCQA
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA
0105	Antidepressant Medication Management	NCQA
n/a	Adherence to Antipsychotics for Individuals with Schizophrenia	CMS
0021	Annual Monitoring for Patients on Persistent Medications	NCQA
0006/0007	CAHPS Health Plan Survey v 4.0—Adult Questionnaire with CAHPS Health Plan Survey v 4.0H—NCQA Supplemental	AHRQ, NCQA
0648	Care Transition—Transition Record Transmitted to Health Care Professional	AMA-PCPI
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
1391	Prenatal and Postpartum Care: Postpartum Care Rate	NCQA

Properties of the Medicaid Adult Core Set Measures

Measure Properties	Measure Sub-Properties	Measure Count (Total n=26)
NQF Endorsement	Endorsed	21
	Not Endorsed	5
Measure Type	Outcome	7
	Process	19
Care Setting	Ambulatory Care	22
	Behavioral Health	5
	Home Health	5
	Hospital/Acute Care	10
	Post-Acute/Long-Term Care	4
	Other (e.g., Pharmacy)	3
Alignment	Included in Another Federal Program	19
	Included in a State Duals Integration Demonstration	16

Recommendation on Risk Adjustment

Challenge: There is not a risk adjustment methodology for the Medicaid population in the Plan All Cause Readmissions measure.

- Recommendation:
  - Risk adjustment is necessary to fairly interpret measure results. Without it, one cannot determine whether differences in performance are due to overall quality or the characteristics of the denominator population.
  - Workgroup strongly supported CMS' plans to work with the measure steward to develop a risk adjustment model for the Medicaid population.
  - Workgroup envisioned broader applications of the risk adjustment model to other Medicaid measures.

Recommendation on Paired Measures

Challenge: Measures #0647 and #0648 are *paired measures* designed to be used together, but only #0648 is included.

- Recommendation:
  - #0647 relates to provider-to-patient communication and #0648 relates to provider-to-provider communication; both are vital for safe and effective care transitions after hospital discharge.
  - These facility-level measures have proven difficult for states to operationalize. However, they were included to prompt Medicaid programs to develop relationships with providers.
  - CMS should consider adding #0647 Transition Record with Specified Elements Received by Discharged Patients to the measure set; doing so enhances person-centeredness and may also improve the feasibility of data collection for Timely Transmission of Transition Record.

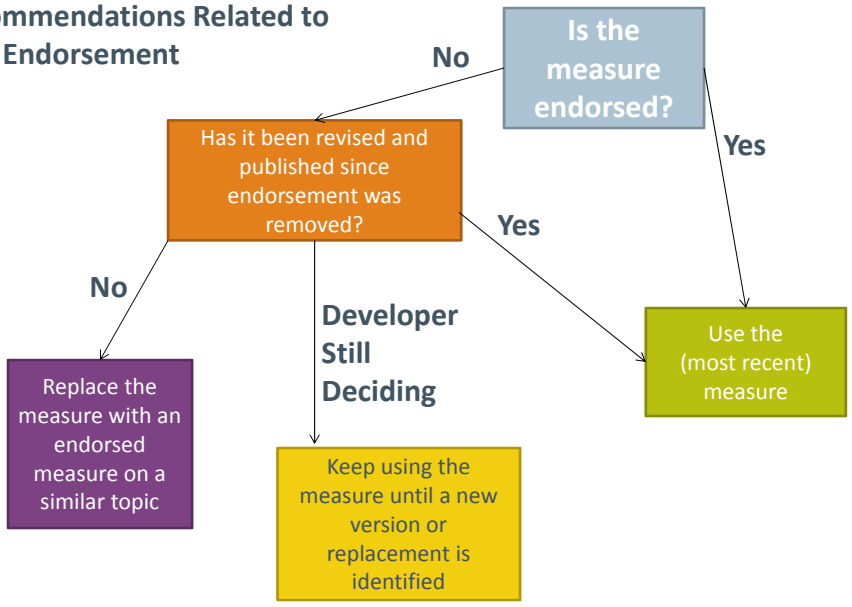
Recommendations Related to NQF Endorsement

Challenge: Several measures have lost endorsement since the Core Set was published.

- #0031 “Breast Cancer Screening”
- #0403 “Annual HIV/AIDS Medical Visit”
- #0021 “Annual Monitoring for Patients on Persistent Medications”
- #1690 “Adult BMI Assessment”

MSC #1 states a requirement for the use of NQF-endorsed measures, if available, because of the recognized rigor of the endorsement process.

Recommendations Related to NQF Endorsement



Recommendations Related to NQF Endorsement

Not Currently Endorsed but a Revision Exists or Is Being Considered

- In cases when a measure has lost endorsement but the steward intends to resubmit an updated version, use of the most current version should proceed.
  - Example: "Breast Cancer Screening" is not currently endorsed but was updated in HEDIS specifications for 2014.
  - Updates pending on "Annual Monitoring for Persistent Medications" and "Adult BMI Assessment."
  - Developer intends to submit the revised measures at the next opportunity offered by NQF.

Recommendations Related to Endorsement

Not Currently Endorsed and No Plans to Update

- In cases when a measure has lost endorsement but the steward has no intention to provide an update, use of the measure should stop and a suitable replacement on the same topic should be identified.
- Example: "Annual HIV/AIDS Medical Visit"
  - CMS should consider a replacement, such as:
    - **#2082 "Viral Load Suppression"**
    - #0573 "HIV Screening: Members at High Risk of HIV"
    - #2083 "Prescription of HIV Antiretroviral Therapy Regardless of Age"

Strengthening the Measure Set

- Workgroup recommended that the measure set be strengthened over the long term by adding measures in key areas:
  - Mental health screening (potential to develop a composite).
  - Access to services, particularly for reproductive health services and for individuals with disabilities.
  - Wrap-around services to mitigate social determinants of health (e.g., transportation).
  - Individual goals for care (e.g., functional status, quality of life).
- Workgroup suggests that CMS consult the MAP Family of Measures for Dual Eligible Beneficiaries for additional measures or measure concepts.

Discussion: Implementation Issues to Monitor

- What information about the program implementation experience is needed to support MAP's future decision-making?
- Workgroup suggests:
  - Feasibility of data collection at the state level and data collection methodologies.
  - How states act on the quality information they received from participating in the program.
  - Testing scientific properties of measures altered after endorsement to ensure that they have retained integrity.

Opportunity for Public Comment

Review Integrated Approach to Identifying the MAP Affordability Family of Measures

NQF's Efforts to Address Affordable Care

Key Questions:

1. How do various stakeholders define affordability and what do they consider most important to measure?
   - MAP Affordability Family of Measures
   - Efficiency Measurement: The Missing Link Between Cost and Quality (RWJF)
2. What measures are available to assess affordability and should be readily implemented in accountability programs?
   - Cost and Resource Use Measures Consensus Development Project
   - Episode Grouper Measure Evaluation Criteria Consensus Development Project
   - MAP Affordability Family of Measures
3. What are the key methodological challenges to developing and using measures of affordability?
   - Efficiency Measurement: The Missing Link Between Cost and Quality (RWJF)
   - MAP Affordability Family of Measures

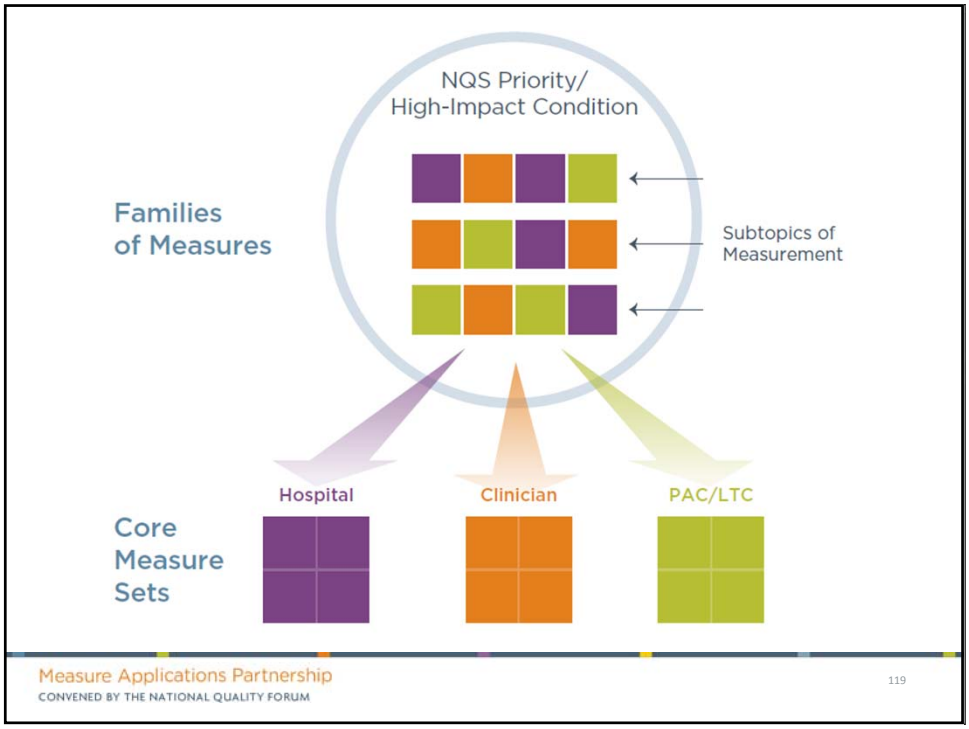
MAP Affordability Family of Measures

Families of Measures

Families of Measures and Core Measure Sets to Align Performance Measurement Across Federal Programs and Public and Private Payers

Family of measures – "related available measures and measure gaps for specific topic areas that span programs, care settings, levels of analysis, and populations" (e.g., care coordination family of measures, diabetes care family of measures)

Core measure set – "available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., PQRS core measure set, hospital core measure set, dual eligible beneficiaries core measure set)


NQS Priority/
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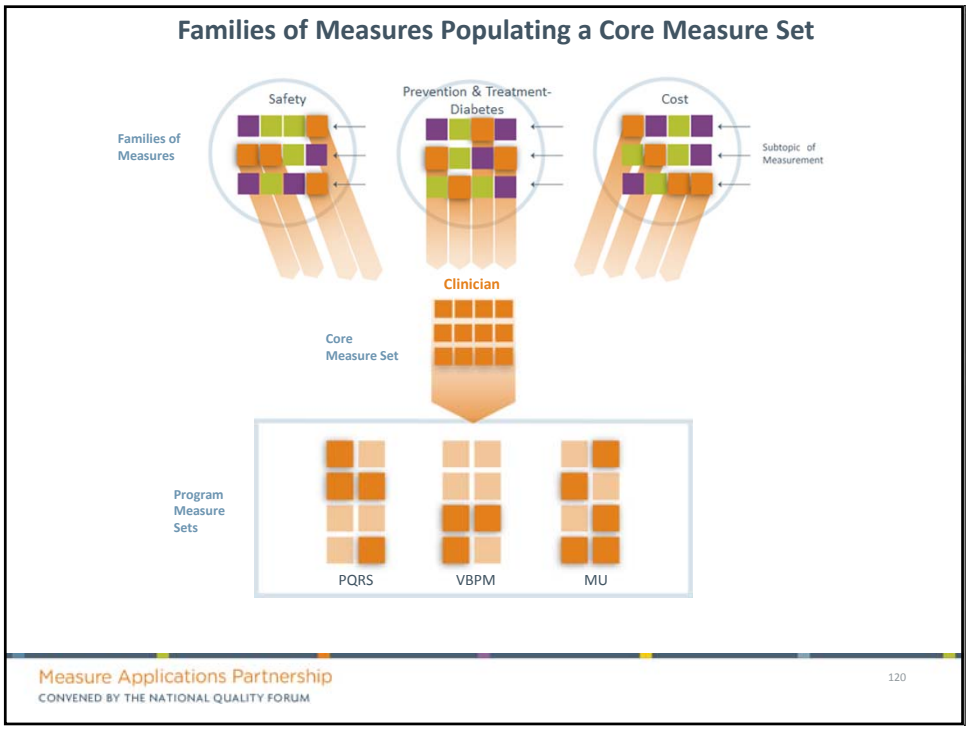
Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM
119


Families of Measures Populating a Core Measure Set
Safety
Prevention & Treatment-
Diabetes
Cost
Families of
Measures
Subtopic of
Measurement
Clinician
Core
Measure Set
Program
Measure
Sets
PQRS
VBPM
MU
Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM
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Approach to Developing an Affordability Family

1. Develop consensus-based definitions of affordability

- Define the parameters of affordability taking into account multiple stakeholders perspectives
- Conduct stakeholder outreach to understand the range of definitions and perspectives

Approach to Developing an Affordability Family

2. Identify and Prioritize High-Leverage Opportunities for Measurement

- Identification of high-leverage opportunities
  - Major cost drivers across settings and populations(e.g. vulnerable populations, commercially insured, Medicaid, Medicare)
  - National Quality Strategy
  - IOM's Healthcare Imperative: Lowering Costs and Improving Outcomes report
  - Public-sector efforts
  - Private-sector efforts
- Prioritization of high-leverage opportunities
  - Impact, improvability, inclusiveness
  - Areas of waste, inefficiency, overuse
- Consider how high-leverage opportunities span the patient-focused episode of care
  - Do the high-leverage opportunities span settings, levels of analysis?
  - How should measures addressing the high-leverage opportunities vary across settings?

Approach to Developing an Affordability Family

3. Scan of Available and Pipeline Measures that Address the High-Leverage Opportunities

- NQF-endorsed portfolio of measures.
- Measures in federal programs.
- Available private sector efforts.

Approach to Developing an Affordability Family

4. Define the Affordability Family of Measures and Measure Gaps

- Considerations for defining the family
  - Do available measures address the relevant care settings, populations, level of analysis?
  - When appropriate, are measures harmonized across settings, populations, levels of analysis?
  - What are the types of measures available for each setting, population, level of analysis?
- Consider implementation barriers.

Approach to Developing an Affordability Family

5. Consider the application of principles developed through the RWJF work in the context of federal and private programs

- MAP will provide input on the principles developed by the expert panel convened through the RWJF project,
- These principles will explore:
  - Linking cost and quality
  - Attribution
  - Risk adjustment
  - Exclusions
  - Reliability/small numbers
  - Patient perspectives on affordability

Efficiency Measurement: The Missing Link Between Cost and Quality

Efficiency Measurement: The Missing Link Between Cost and Quality

Key Objectives

- Provide guidance on methodological challenges on linking cost measures and quality measures;
- Provide guidance more narrowly on individual cost of care measures; and
- Lay out a path towards more patient-oriented cost measures.

Efficiency Measurement: The Missing Link Between Cost and Quality

Approach

- Commission two white papers:
  - Technical issues related to linking cost and quality; and
  - Patient perspective of affordability.
- Convene expert panels:
  - Develop principles for the future development, testing, and reporting of measures to evaluate efficiency.
  - Outline a strategy for the development of more patient-oriented cost measures.
- Conduct environmental scans of approaches to linking cost and quality and available measures that could be used to assess costs that matter most to patients.
- Synthesize results into principles for application of cost measures.

Review Approach for Assessing the Health Information Exchange Quality Rating System

Health Insurance Exchange (HIX) Quality Rating System (QRS) Task Force Membership

Workgroup Chair: Elizabeth Mitchell

Organizational Members

Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
The Advanced Medical Technology Association	Steve Brotman, MD, JD
Aetna	Andrew Baskin, MD
America's Essential Hospitals	David Engler, PhD
America's Health Insurance Plans	Aparna Higgins, MA
American Association of Retired Persons	Joyce Dubow, MUP
American Board of Medical Specialties	Lois Nora, MD, JD, MBA
American Medical Group Association	Samuel Lin, MD, PhD, MBA, MPA, MS
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	David Ferriss, MD, MPH
Consumers' CHECKBOOK	Robert Krughoff, JD
Humana, Inc.	George Andrews, MD, MBA, CPE
Iowa Healthcare Collaborative	Lance Roberts, PhD
March of Dimes	Cynthia Pellegrini
Memphis Business Group on Health	Christie Upshaw Travis, MHSA
National Business Coalition on Health	Colleen Bruce, JD
National Partnership for Women and Families	Emma Kopleff, MPH
SNP Alliance	Chandra Torgerson, MS, RN, BSN
The Brookings Institute	Mark McClellan, MD, PhD

HIX QRS Task Force Membership

Subject Matter Experts

Child Health	Richard Antonelli, MD, MS
Health IT	Thomas von Sternberg, MD
Measure Methodologist	Debra Saliba, MD, MPH
Medicaid ACO	Ruth Perry, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members

Centers for Medicare and Medicaid Services (CMS)	Deborah Green
Health Resources and Services Administration (HRSA)	Terry Adirim, MD, MPH

HIX QRS Task Force Charge

- Advise the MAP Coordinating Committee on recommendations for the hierarchical structure, organization, and measures for the child and family core sets of the QRS.
  - MAP is not providing recommendations on the marketplace websites, materials, displays, or minimum benefits.
  - The QRS' primary purpose is to inform consumer choice of Qualified Health Plans (QHPs) in the marketplaces.
- The task force is time-limited and consists of current MAP members from the MAP Coordinating Committee and all MAP workgroups with relevant interests and expertise.

Timeline for HIX QRS Task Force Activities

September 26: Task Force Web Meeting	• Review task force charge, background of the QRS, and relevant populations • Consider health plan information available to consumers and define scope of MAP's input
October 18: Task Force Web Meeting	• Define the highest leverage measurement opportunities for the marketplace populations • Review the MAP Measure Selection Criteria (MSC) and consider how it will be used in marketplace QRS decision-making framework • Consider the ideal hierarchy and measurement domains for consumer decision-making
November 20-21: Task Force In-Person Meeting	• Develop recommendations and rationale regarding measures for inclusion in QRS • Develop recommendations and rationale regarding structure of QRS • Identify gaps in measure to enable consumer decision-making
December: Public Comment Draft Report	• Task force review of draft report via email • Report posted to NQF website for a two-week public comment period
January 7-8: MAP Coordinating Committee In-Person Meeting	• MAP Coordinating Committee review of public comment draft and public comments received • HIX QRS Task Force will be asked to join by phone • Finalize recommendations and rationale on measures for inclusion and structure of QRS
January: Final Report	• Submit final report to DHHS

MAP Input on the Marketplaces Quality Rating System

Final Report Outline

- Introduction
- Enabling consumer choice in healthcare marketplaces–the ideal state
  - Presenting information to consumers (structure, domains)
  - Providing meaningful information to consumers (high-leverage opportunities for measurement)
- Input on Marketplaces QRS
  - Input on QRS structure (structure, hierarchy, domains)
  - Input on proposed core child and family measures for the QRS
  - Identified measure gaps
- Path Forward
  - Addressing measure gaps
  - Changes to structure and hierarchy over time
  - Innovative directions
- Conclusion

Overview of the Health Insurance Marketplaces and Quality Rating System

Statutory Authority

- Affordable Care Act (ACA) Sections 1311-1343 of Subtitle D of Title I.
- National infrastructure to offer citizens health insurance through Affordable Insurance Exchanges or Health Insurance Marketplaces.
- Marketplaces are designed to provide a place for individuals or small businesses to:
  - Search for health insurance coverage options and
  - Identify costs and benefits to health insurance coverage.
- Marketplaces will provide information on health plans based on relative quality and price to individuals and employers through the QRS.
  - Enrollee satisfaction information will be provided to individuals and employers on plans with more than 500 enrollees the previous year.
- Two types of marketplaces:
  - Affordable Insurance Exchange (Individual Marketplace).
  - Small Business Health Options Program (SHOP Marketplace).

Overview of the Health Insurance Marketplaces and Quality Rating System

State and Federal Marketplaces

- States can choose to operate marketplaces in the opt-in model.
- The federal government will automatically operate a marketplace (federally facilitated marketplace) in every state that does not opt to operate their own.
  - Some states have been approved to develop independent marketplaces that meet federal requirements.
  - Other states are creating a variety of partnerships to create marketplaces with the federal government.
- The government operating the marketplace will be responsible for implementing four core exchange functions:
  - Eligibility and enrollment.
  - Plan management.
  - Consumer assistance, outreach, and education.
  - Financial management.
- Marketplaces are open for enrollment beginning October 1, 2013 with coverage beginning as early as January 1, 2014.

Overview of the Health Insurance Marketplaces and Quality Rating System

Population Description

- Over 47 million non-elderly uninsured people in the US (aged 0-64).
  - Approximately 17 million of them will be newly insured in 2014.
  - 90% of individual marketplace enrollees will receive federal subsidies.
  - Total marketplace population is projected to reach 29 million in 2021.
  - Median age expected to be 33, more than 50% expected to be unmarried.
  - Marketplace population is anticipated to have a median income of 166% of FPL, compared to the currently insured with medium income of 333% FPL .
- Approximately 40% of the expected individual marketplace enrollees will come from five states: California, Texas, Florida, New York, and Illinois.
- Marketplaces are anticipated to be more ethnically diverse than the currently insured population.
- Uninsured rates among young adults continue to remain high compared to other age groups.
- Individuals without a high school degree are less likely to be currently insured and will make up a majority of the newly insured population.
- The marketplace population is less likely to report excellent or very good health than the traditional market.

What Quality Information is Necessary to Enable Consumer Decision-Making?

Health Plan Functions

- Network Management
  - Contract with providers and facilities
  - Maintain adequate services and access
- Benefit Design
  - Services for members
  - Incentives for members
- Care Management
  - Prevention, treatment, and disease management programs
  - Care coordination across multiple clinicians and facilities
- Provider Payment
  - Claims adjudication
  - Incentives for providers
- Customer Service
  - Member information
  - Complaints
  - Education
- Other?

What Quality Information is Necessary to Enable Consumer Decision-Making?

Previous Findings Regarding Consumer Choice of Exchanges

- Information should be able to be interpreted "at-a-glance."
  - High-level synthesized quality information with opportunities to drill down.
- Need strong decision-making information and tools about key issues including cost, quality, and participating providers.
- Consider how information is interpreted by consumers.
  - Different populations using marketplaces will have different priorities.
  - Consumers are reluctant to choose low-cost options, even when high-quality.

What Quality Information is Necessary to Enable Consumer Decision-Making?

Previous Findings Regarding Consumer Choice of Exchanges

- Provide information on features valued by consumers:
  - Provider choice, including self-referral to a specialist.
  - Access to care when needed.
  - Costs.
  - Additional benefits (health and wellness programs, dental and vision benefits).
  - Plan administration.
- Quality Measures:
  - Experience, quality, and cost should be equally prominent.
  - Use endorsed measures (particularly HEDIS and CAHPS).
  - De novo measures may be needed.
  - Integrate complaints and grievances information with all performance information.

What Quality Information is Necessary to Enable Consumer Decision-Making?

Health Plan Information

- Accreditation and Recognition Programs
  - URAC, The Joint Commission, Accreditation Association of Ambulatory Health Care, Accreditation Commission for Health Care (Home Health and alternate site providers), etc.
- Structured Rating and Ranking Systems
  - Medicare Star programs, NCQA/ConsumerReports, JD Power, U.S. News, etc.
  - Stars, points, ranks from surveys, standards, and reported data on health plans, hospitals, nursing homes, etc.
- Consumer Direct Commenting
  - HealthGrades, Angie's List, WebMD, ZocDoc, Healthline, etc.
  - Locations, hours, affiliations, impressions, experiences, etc.

What Quality Information is Necessary to Enable Consumer Decision-Making?

Examples of Health Marketplace Quality Rating Systems

- 11 state-operated marketplaces have plans to display health plan quality information prior to the federal deadline.
  - Nine states have indicated they plan to display quality information in 2014.
  - Two states, New Mexico and Washington, plan to display quality information in 2015.
- 6 states and the District of Columbia do not plan to display health plan quality in the marketplaces prior to the federal requirement in 2016.
- Nevada has not yet determined whether it will display quality information prior to the federally required deadline in 2016.

What Health Plan Information Is Most Important to Enable Consumer Decision-Making?

National Quality Strategy

- Health and Well-being
  - Health promotion programs, behavioral health management
- Prevention and Treatment of Leading Causes of Mortality
  - HEDIS, clinical outcomes, disease management
- Person- and Family-Centered Care
  - CAHPS, HCAHPS, consumer engagement
- Patient Safety
  - Safety indicators, risk-adjusted mortality, hospital complications, never-events
- Effective Communication and Care Coordination
  - CAHPS, HCAHPS
- Affordable Care
  - Plan benefit and cost rankings, coverage features, value, payment reform characteristics

Defining MAP's Input

Task Force Input

- QRS Structure needs to focus on the consumer by providing information that is:
  - Usable and of interest to consumers.
  - Accessible and can be understood by consumers.
  - Interactive and customizable allowing consumers to emphasize value on different performance information.
  - Needed to make informed choices–cost, experience, outcomes.
- Need to expand beyond existing health plan-level quality measures (e.g., HEDIS,CAHPS).
  - Recognize initial start will be limited to existing information.
  - QRS needs to evolve over time to include additional measures.
- Alignment and Parsimony are Critical
  - Align with existing health plan programs.
  - Begin with few categories of measures (e.g., roll-ups aligned with triple aim).

Defining MAP's Input

Task Force Input: Measures Needed

- Cost: Total out of pocket costs, potential financial risk.
- Experience: Need to incorporate qualitative consumer information into existing methods of assessing consumer experience.
- Outcomes: Patient reported outcomes and other clinical quality outcomes are needed.
- Plan functions:
  - Quality of available providers (e.g., provider availability, provider ratings).
  - Managing costs (e.g., eValue8 questions).
  - Additional benefits (e.g., programs targeted to patients).

Defining MAP's Input

What information do consumers and small employers need to select health plans?

- Existing health plan-level quality measures (e.g., HEDIS,CAHPS) that have been traditionally used in health plan reporting programs?
- Information purchasers have required of health plans (e.g., cost sharing, provider measurement and rewards)?
- Provider-level quality information on clinicians and facilities within plans' networks?
- Direct consumer commenting (e.g., reviews, experience)?
- Other?

Opportunity for Public Comment

Summary and Next Steps

Upcoming MAP Coordinating Committee Meetings

All MAP Web Meeting

December 4, 2013 (1:00-3:00pm Eastern)

In-Person Meeting

January 7-8, 2014