The State of Cost and Resource Use Measurement

National P4P Summit
San Francisco
March 25, 2014

IHA
INTEGRATED HEALTHCARE ASSOCIATION

NATIONAL QUALITY FORUM

HealthPartners®

Welcome & Introductions

- Dolores Yanagihara, Integrated Healthcare Association (IHA)
- Susan Knudson, HealthPartners
- Taroon Amin, National Quality Forum (NQF)

Agenda

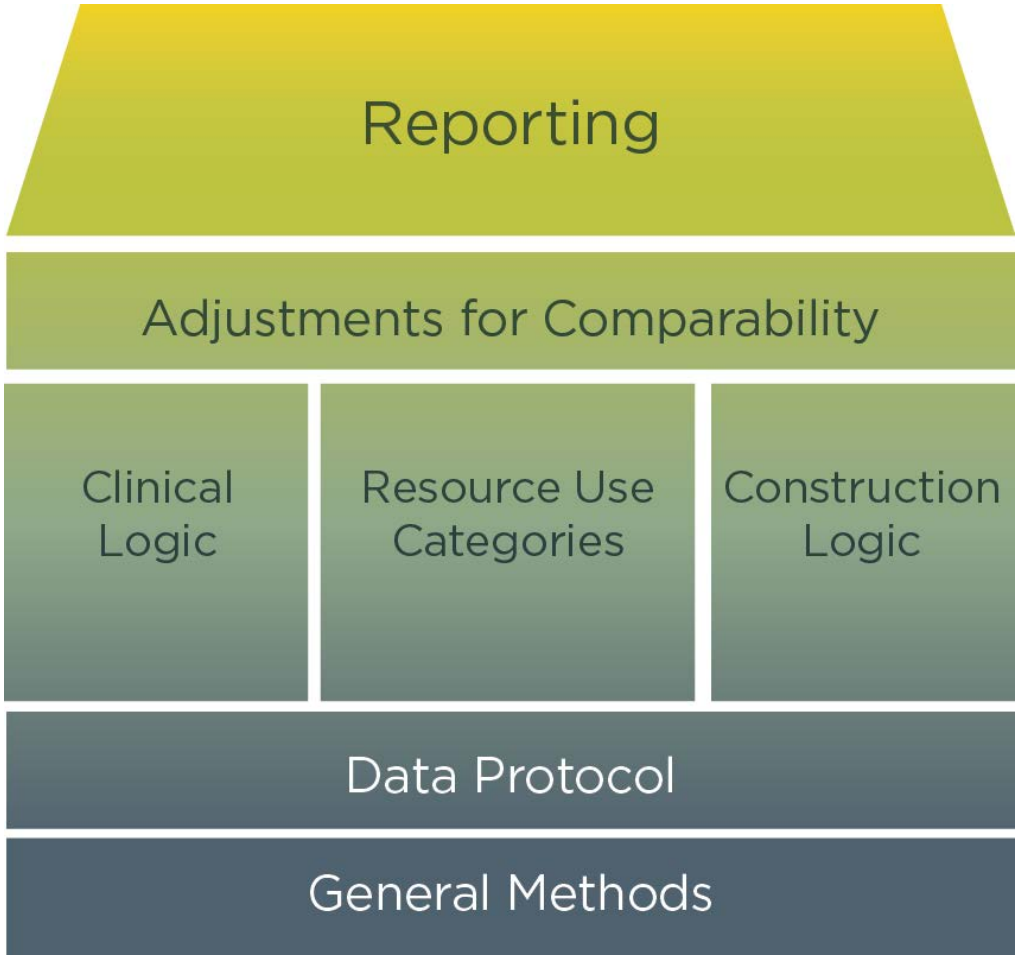
1. Current state of cost/resource use measurement
2. Driving toward efficiency measurement
3. Measurement alignment and its challenges

National Consensus Standards for Cost & Resource Use

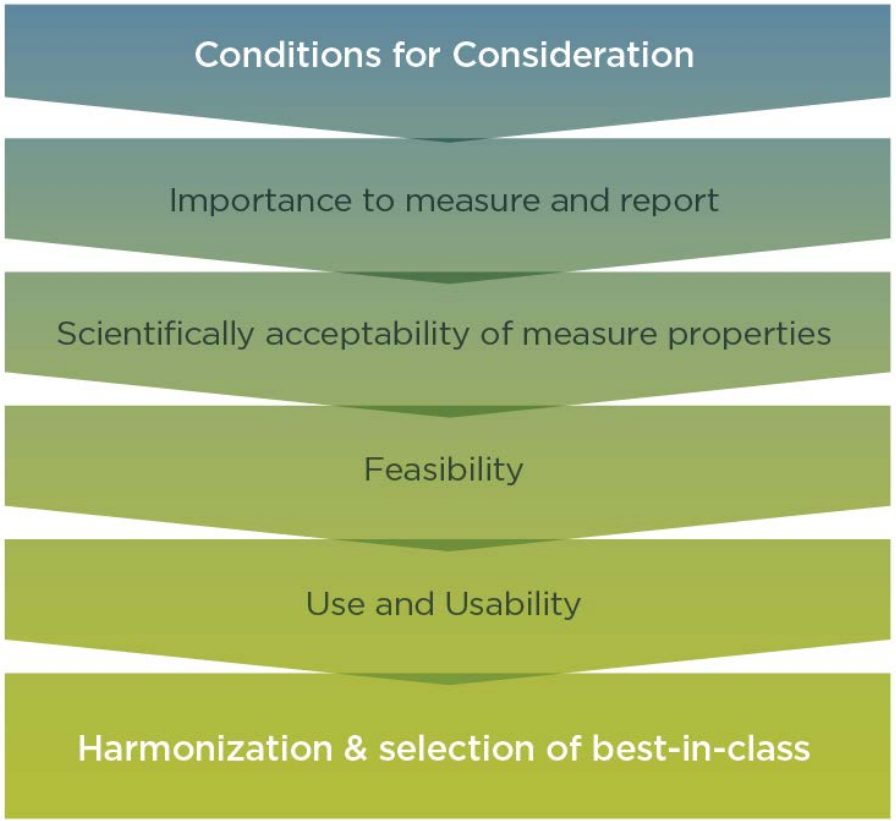
Defining Resource Use Measures

- Broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (may include diagnoses, procedures, or encounters).
  - A resource use measure counts the frequency of defined health system resources; some further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource.

Building Resource Use Measures



NQF Measure Evaluation Criteria



Currently Endorsed Cost & Resource Use Measures

- Endorsed January 30, 2012:
  - 1598: Total Resource Use Population-based PMPM Index (HealthPartners)
  - 1604: Total Cost of Care Population-Based PMPM Index (HealthPartners)
  - 1558: Relative Resource Use for People with Cardiovascular Conditions (NCQA)*
  - 1557: Relative Resource Use for People with Diabetes (NCQA)
- Endorsed March 30, 2012:
  - 1560: Relative resource use for people with asthma (*NCQA*)**
  - 1561: Relative resource use for people with COPD (*NCQA*)**
  - 1609: ETG-based hip/knee replacement cost-of-care *(Ingenix)*
  - 1611: ETG-based pneumonia cost-of-care (*Ingenix*)**
- Endorsed December 6, 2013:
  - 2158: Medicare Spending per Beneficiary (MSPB) *(CMS)*

  - *Up for Maintenance in Phase 2
  - **Up for Maintenance in Phase 3

Comparing Approaches

	HealthPartners	NCQA	Ingenix
Measure Type	Per-capita	Condition-specific per-capita	Episode-based
Data Sources	Administrative Claims	Administrative Claims, EHR, Imaging/ Diagnostic Study, Laboratory, Pharmacy, Registry, Paper Records	Administrative Claims
Lowest Level of Analysis	Physician group	Physician Group	Physician
Tested Population	Commercial	Commercial, Medicaid, Medicare	Commercial
Risk adjustment	Johns Hopkins ACG's	HCC's	ETG-based
Costing Approach	Actual prices paid & Standardized prices	Standardized Prices	Actual prices paid
Proprietary components (Y/N)	Yes – Risk Adjuster (ACG)	No	Yes - Measure and Risk Adjuster
Endorsed Measures	Total cost of care, Total resource use	Asthma, COPD, Cardiovascular, Diabetes	Pneumonia, hip and knee replacement

Upcoming Cost/Resource Use Measures

Phase 1: Total cost per capita and episode-based measures

- 2 measure submissions
  - 2158: Medicare Spending per Beneficiary (MSPB) – Endorsed December 2013
  - 2165: Standardized-Price Total Per Capita Per Beneficiary (FFS)-Not Endorsed

Phase 2: Cardiovascular Condition-Specific Measures

- 3 measure submissions
  - 1558: Relative Resource Use for People with Cardiovascular Conditions *(NCQA)**
  - 2431: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI) *(CMS/Yale)*
  - 2436: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF) *(CMS/Yale)*

Phase 3: Pulmonary Condition-Specific Measures

- Measure Submission Deadline – April 18, 2014
  - 1560: Relative resource use for people with asthma (*NCQA*)*
  - 1561: Relative resource use for people with COPD (*NCQA*)*
  - 1611: ETG-based pneumonia cost-of-care (*Ingenix*)*
  - Pneumonia Measure Submission *(CMS)*

*Maintenance Measures

Lessons from the Field

- What are the highest impact measures of cost/resource use from HealthPartners's perspective?
- What are the challenges of the various approaches?
- Where does the field need to go?

HealthPartners Overview

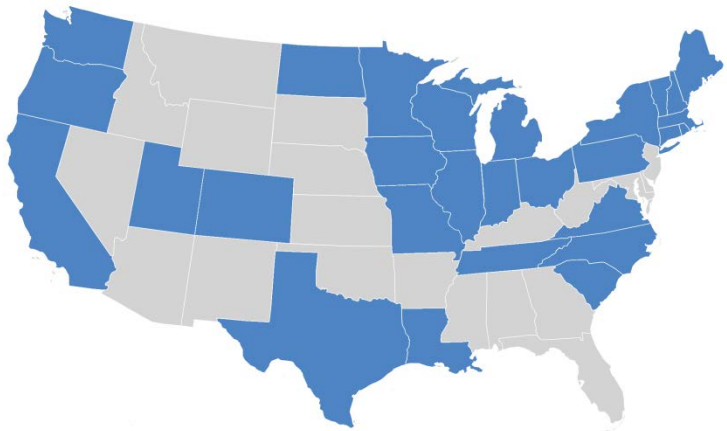
- Non-profit, consumer-governed – 22,500 team members
- Integrated care and financing system
  - Health plan - 1.5 million members
  - Medical Clinics
    - 1,700 physicians, 40 primary care locations, plus 35 medical specialties
    - 1 million patients, multi–payer
  - Dental Clinics
    - 60 dentists across 20 locations, plus 6 dental specialties
  - Six Hospitals
    - Level 1 trauma and tertiary center
    - Acute care hospitals
    - Critical access hospitals

High Impact Measures

WHAT IS TOTAL COST OF CARE?

- **Population-based model**
- **Attributable** to medical groups for **accountability**
- Includes **all care, treatment costs**, places of service, and provider types
- Measures **overall performance relative to other groups**
- **Illness-burden adjusted**
- **Drillable** to condition, procedure and service level
- Identifies **price differences and utilization drivers**
- National Quality Forum-endorsed

UPTAKE ACROSS THE COUNTRY



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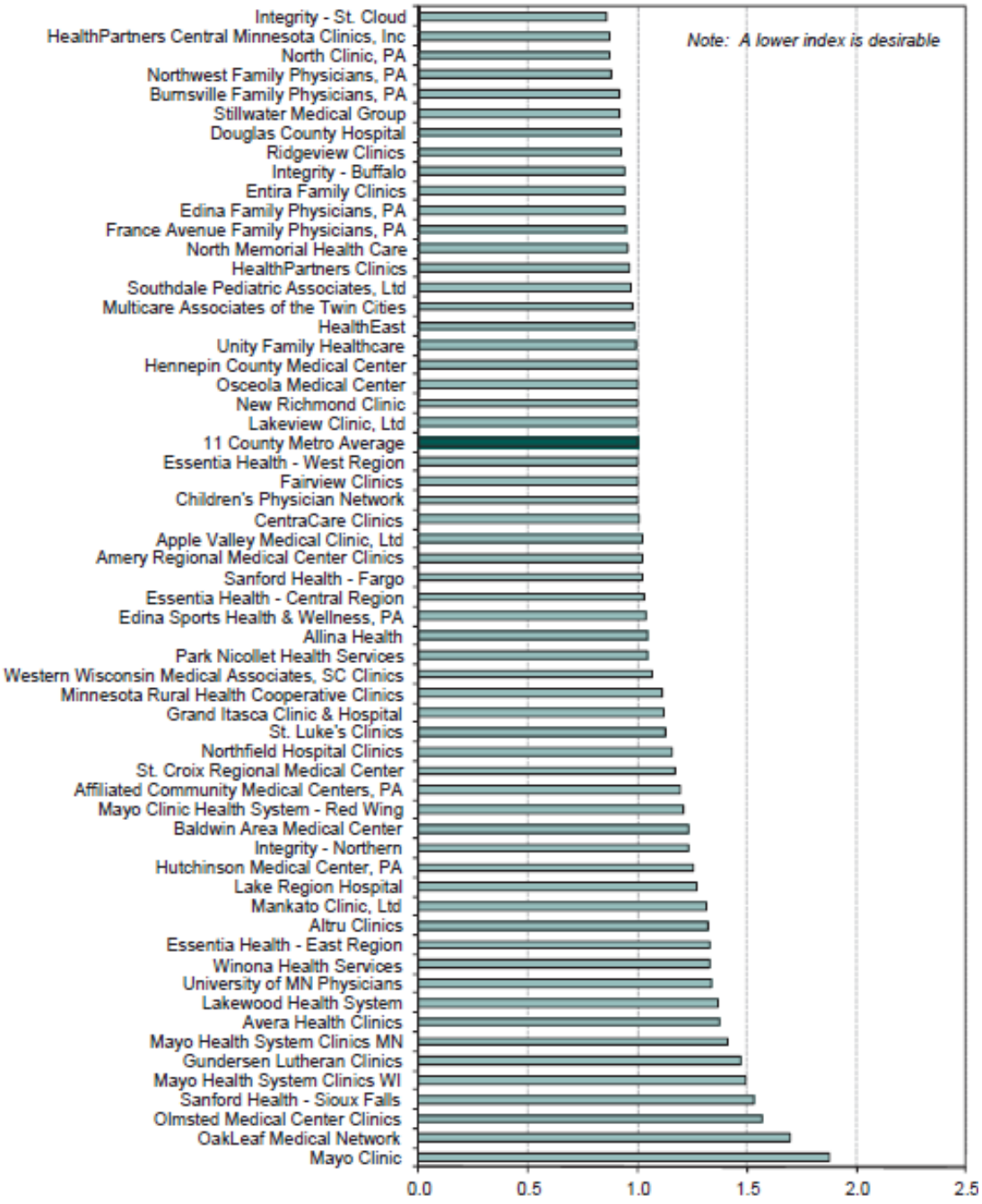
Total Cost Index



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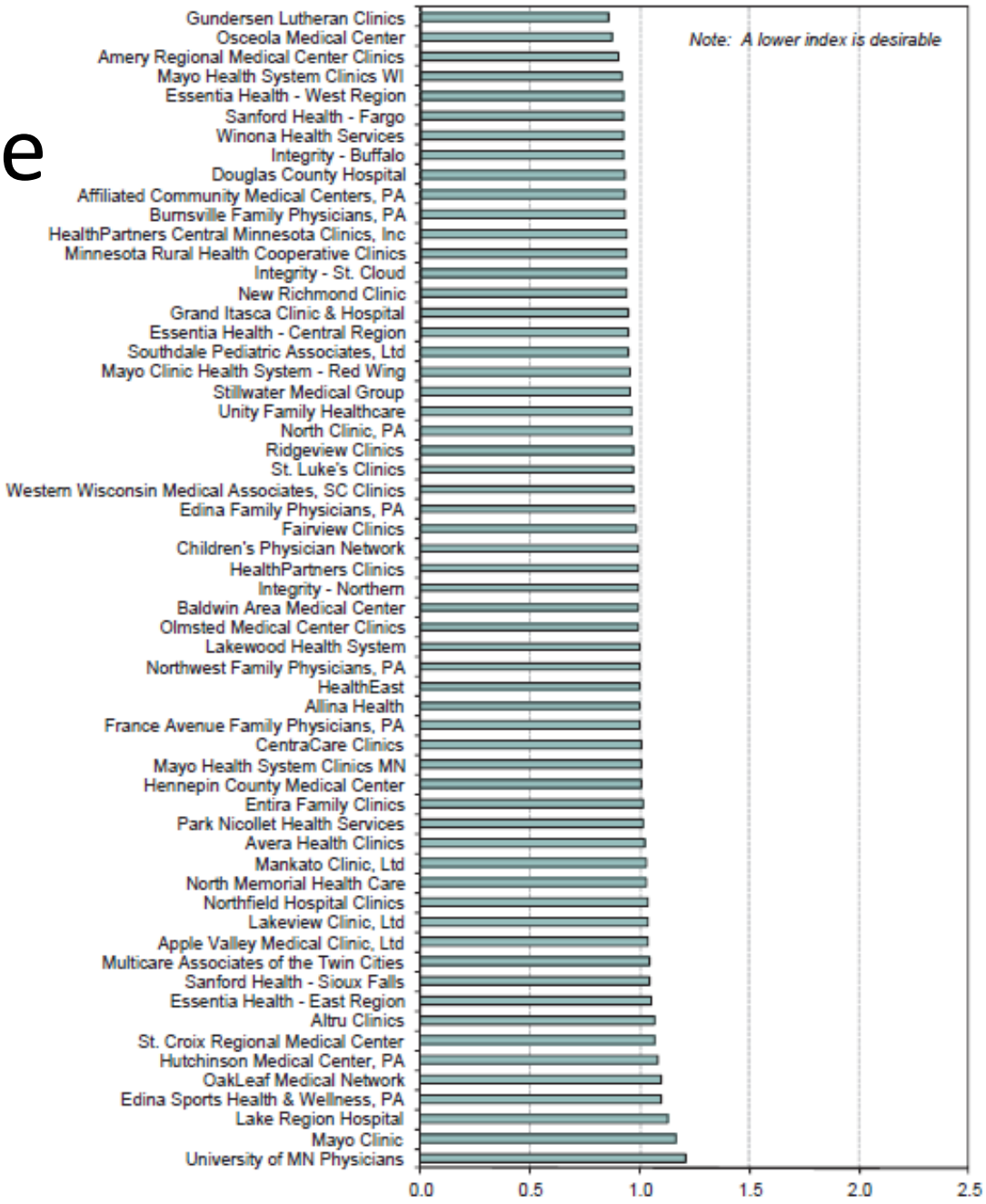
Total Resource Use Index



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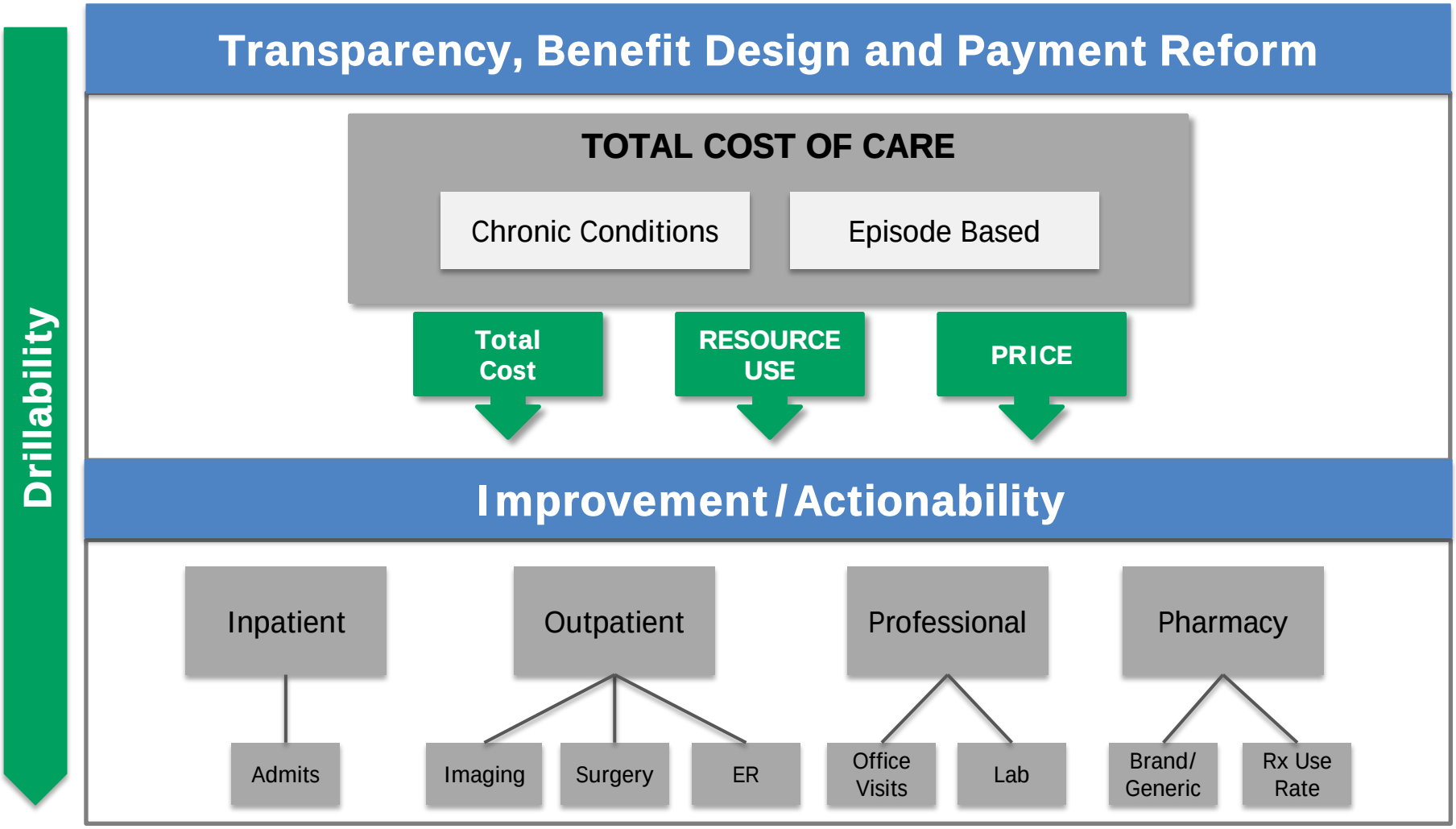
TCOC Analytical Pathway and Uses



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Total Cost of Care data

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Total Cost of Care Report - Rolling 12 Months: January through December - 2010, 2011 & 2012
-Risk Adjusted Total Cost of Care Metrics
-Total Spend including Clinics, Hospitals, Rx and Referral Providers
-Attributed, Commercial, Continuously Enrolled, Excluding Babies and 65+
-Total Reimbursement Capped at $100,000

Potential Opportunity (TCI)
Potential Opportunity (Pricing)
Potential Opportunity (RUI)
Potential Opportunity (Patient Mgmt Util)
Potential Opportunity (High Cost Util)

Highlighted cells indicate >= 1.01 after rounding

	Members			Average ACG Score			TCI			Price Indexed to 2012			Resource Use Indexed to 2012		
Provider Group	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**	**2010**	**2011**	**2012**
Provider Group XYZ	96,121	89,634	80,854	1.07	1.05	1.05	0.96	0.97	0.96	0.92	0.95	0.97	1.00	0.99	0.99
Metro Total	**308,570**	**299,929**	**295,973**	**1.06**	**1.05**	**1.05**	**1.00**	**1.00**	**1.00**	**0.94**	**0.97**	**1.00**	**1.02**	**1.00**	**1.00**

	Patient Management Utilization Measures															
	E&M Count Index (Total)		E&M Count Index (PC)		E&M Count Index (Spec)		% PC E&M*		Lab/Path Count Index		Standard Rad		Rx Count Index		% Generic Rx*	
Provider Group	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Provider Group XYZ	0.97	0.98	0.94	0.93	0.99	1.03	50%	48%	1.07	1.08	1.01	1.01	0.97	0.96	83%	87%
Metro Total	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**51%**	**51%**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**82%**	**86%**

**Measure is not risk adjusted*

	High Cost Utilization Measures													
	Admit Count Index		IP Surg Count Index		ER Count Index		OP Surg Count Index		Hightech Rad Index (ER)		Hightech Rad Index (nonER)		% ER Hightech Rad*	
Provider Group	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Provider Group XYZ	0.99	0.96	1.02	0.99	0.92	0.96	0.96	0.94	0.92	0.91	0.92	0.90	16%	18%
Metro Total	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**16%**	**17%**

**Measure is not risk adjusted*

	Service Category TCI								Price Index						Resource Use Index					
	IP TCI		OP TCI		Prof TCI		Rx TCI		IP Price		OP Price		Prof Price		IP RUI		OP RUI		Prof RUI	
Provider Group	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Provider Group XYZ	0.96	0.92	0.85	0.89	1.05	1.02	0.95	0.95	0.93	0.90	0.88	0.89	1.03	1.02	1.03	1.02	0.96	1.01	1.01	1.00
Metro Total	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**

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Condition Focused

- Drillable to specific conditions

	Overall Indices			
Condition	Members	TCI	Price Index	RUI
ARTHRITIS	600	1.02	1.02	1.03
ASTHMA	1,500	1.06	1.02	1.03
BACK PAIN	3,500	1.03	0.99	1.04
CHF	50	1.03	1.00	1.03
CHRONIC RENAL FAILURE	105	0.91	1.03	0.89
COPD	175	0.91	1.08	0.85
DEPRESSION	2,300	1.04	0.99	1.05
DIABETES	1,300	1.05	1.00	1.03
HYPERLIPIDEMIA	3,700	1.03	1.02	1.03
HYPERTENSION	3,500	1.06	1.02	1.04
ISCHEMIC HEART DISEASE	350	1.00	0.99	1.00
ALL OTHER CONDITIONS	12,500	1.07	1.02	1.05
Provider XYZ	26,000	1.03	1.00	1.03

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Supporting Provider Improvement

- Augmented by patient management and high cost utilization measures.

	Patient Management Utilization Measures									
Condition	E&M Count Index (Total)	E&M Count Index (Primary Care)	E&M Count Index (Specialty Clinics)	Percent Primary Care E&M		Lab/Path Count Index	Standard Radiology Index	Rx Count Index	Percent Generic Rx	
				Prov	Metro				Prov	Metro
ARTHRITIS	1.02	1.00	1.03	38%	39%	0.96	1.00	1.13	78%	77%
ASTHMA	1.09	1								
BACK PAIN	1.04	1								
CHF	1.20	1								
CHRONIC RENAL FAILURE	1.06	1								
COPD	1.08	1								
DEPRESSION	1.00	1								
DIABETES	1.02	1								
HYPERLIPIDEMIA	1.00	1								
HYPERTENSION	1.03	1								
ISCHEMIC HEART DISEASE	1.00	0								
ALL OTHER CONDITIONS	1.04	1								
Provider XYZ	1.03	1								

	High Cost Utilization Measures							
Condition	Admit Count Index	IP Surgery Count Index	ER Count Index	OP Surgery Count Index	Hightech Rad Svcs Count Index (ER)	Hightech Rad Svcs Count Index (non-ER)	Percent ER Hightech Rad	
							Prov	Metro
ARTHRITIS	0.97	0.85	1.02	0.94	1.06	1.11	11%	12%
ASTHMA	1.02	0.97	1.15	0.88	1.17	1.24	20%	21%
BACK PAIN	1.06	0.99	1.08	0.89	1.11	1.14	17%	17%
CHF	1.00	1.05	0.68	1.69	0.22	1.52	2%	14%
CHRONIC RENAL FAILURE	0.96	0.91	0.78	1.18	0.72	1.43	7%	13%
COPD	0.92	0.89	0.92	1.12	0.86	1.10	11%	13%
DEPRESSION	1.09	0.96	1.11	0.95	1.26	1.09	24%	22%
DIABETES	1.13	1.11	0.91	1.05	1.10	1.08	17%	17%
HYPERLIPIDEMIA	1.02	0.94	0.90	0.94	0.99	1.05	16%	17%
HYPERTENSION	1.07	1.05	0.95	0.97	1.03	1.14	17%	18%
ISCHEMIC HEART DISEASE	0.96	0.91	0.80	0.97	0.50	1.00	10%	18%
ALL OTHER CONDITIONS	1.09	1.32	0.98	1.00	1.03	1.06	20%	20%
Provider XYZ	1.04	1.04	1.03	0.97	1.06	1.08	18%	18%

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Place of Service Opportunity Report

Outpatient vs. Ambulatory Surgery Center Opportunity Report - 12 Months: October 2010 through September 2012

- Total Reimbursement - Non Risk Adjusted, Non Capped
- Attributed,Commercial, Continuously Enrolled, Excluding Babies and 65+
- *Includes Top 20 Procedures, All Others Grouped Together*
- Utilization savings are estimated based on the metro average cost per service

Procedure*	% of procs in surg center	Total Procs	Total Potential Opportunity Dollars	Top Outpatient Facility Utilized by Provider
Procedure 1	6%	100	77,824	Facilty A
Procedure 2	20%	115	67,584	Facility B
Procedure 3	14%	46	64,717	Facility B
Procedure 4	84%	56	52,838	Facility A
Procedure 5	62%	148	49,971	Facility C
Procedure 6	5%	25	48,742	Facility A
Procedure 7	70%	258	46,285	Facility B
Procedure 8	3%	20	43,622	Facility A
Procedure 9	7%	38	39,526	Facility A
Procedure 10	51%	110	37,683	Facility A
Procedure 11	42%	201	35,226	Facility B
Procedure 12	20%	56	29,491	Facility D
Procedure 13	31%	123	27,853	Facility A
Procedure 14	61%	62	25,190	Facility C
Procedure 15	9%	35	22,938	Facility B
Procedure 16	32%	46	22,528	Facility A
Procedure 17	6%	14	21,299	Facility A
Procedure 18	8%	22	19,866	Facility C
Procedure 19	12%	61	17,408	Facility B
Procedure 20	76%	420	15,770	Facility A
All Other Procedures	15%	1,231	625,817	
Total	35%	3,187	1,392,179	
Metro Overall Surgery Center %	45%			

TCI	Surgery Centers - Metro
0.85	Surgery Center A
0.85	Surgery Center B
0.85	Surgery Center C
0.88	Surgery Center D
0.88	Surgery Center E
0.91	Surgery Center F
0.94	Surgery Center G
0.97	Surgery Center H

Current Overall TCI	1.01
Overall TCI Impact if all procedures were performed in a surgery center	-0.02
New Overall TCI if all procedures were performed in a surgery center	0.99

Current OP TCI	0.99
OP TCI Impact if all procedures were performed in a surgery center	-0.07
New OP TCI if all procedures were performed in a surgery center	0.92

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Additional Drill Down

- Generic prescribing opportunities
- Specialty provider use and hospital use, including quality and cost performance
- Trended utilization
- Episode reporting

User guide link:

www.healthpartners.com/tcocuserguide

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IHA Overview

- **Organization:** California multi-sector healthcare leadership group
- **Mission:** Improve quality and lower costs of healthcare
- **Approach:** Multi-stakeholder collaboration incorporating performance measurement & incentive alignment
- **Projects:** Pay for performance, medical technology, clinical data sharing, new payment methods (bundled payment), resource use measurement, and administrative simplification

Context: IHA P4P Program

2003:

First Measurement Year – Quality only

2007:

Payment for Improvement Added – Quality only

2009:

Appropriate Resource Use Measures added

2011:

Total Cost of Care Measure added

2013:

Value Based P4P – Quality and Resource Use integrated into single incentive program

Program Participants

Ten CA Health Plans:

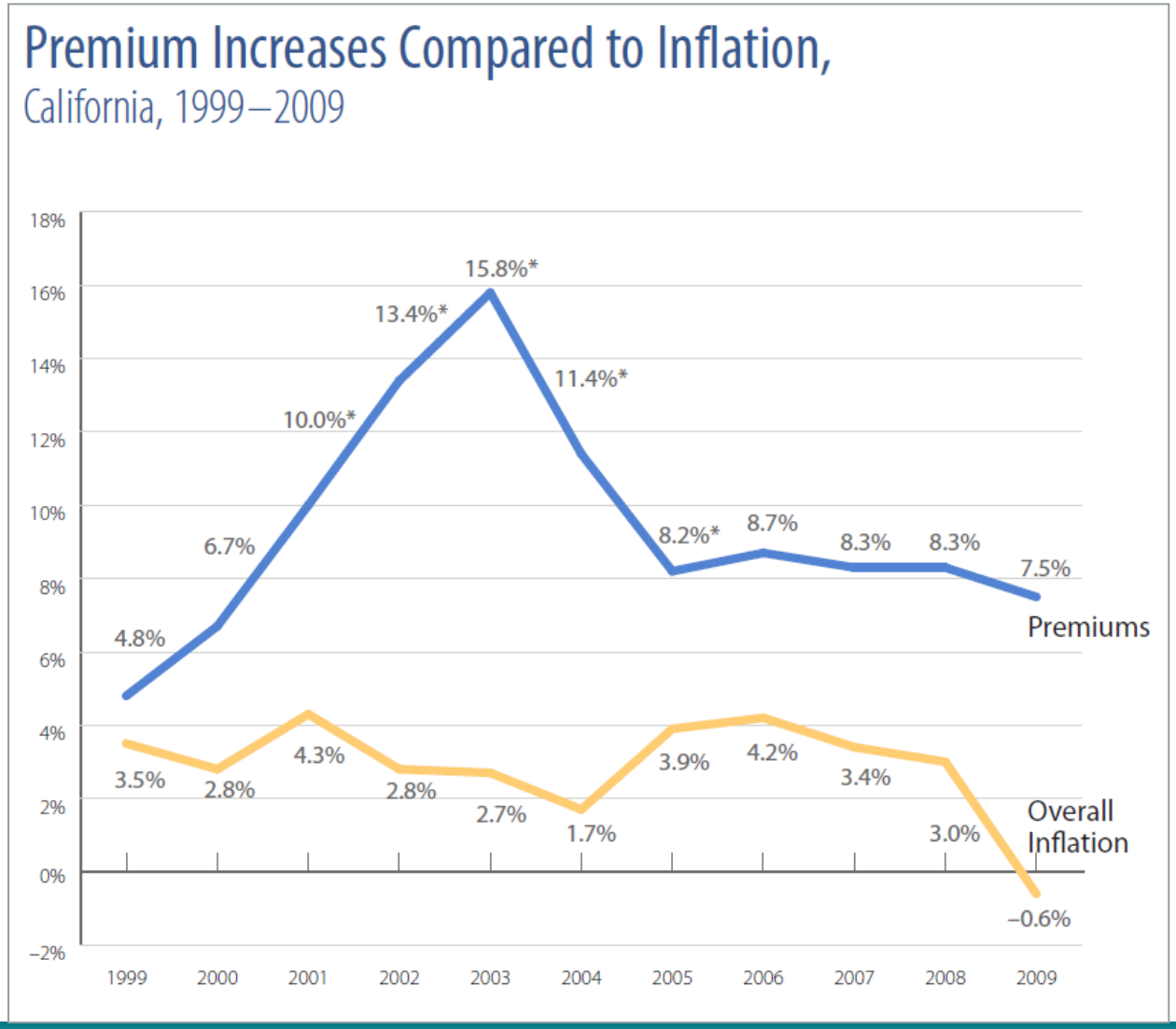
- Aetna
- Anthem Blue Cross
- Blue Shield of CA
- Chinese Community (2012)
- CIGNA
- Health Net
- Kaiser Permanente* (2005)
- UnitedHealthcare
- Sharp Health Plan (2013)
- Western Health Advantage

Physician Organizations:

- 200 medical groups and IPAs
- 35,000 physicians
- 9 million commercial HMO/POS members

** Kaiser Permanente medical groups participate in public reporting only*

Increasing Costs Unsustainable



Source: California Employer Health Benefits Survey, CHCF, April 2010

Potentially Avoidable Hospitalizations

- Used AHRQ Prevention Quality Indicators
- Added risk adjustment to account for prevalence of condition in population
- Measured specific conditions as well as roll-up across conditions
- Findings:
  - Physician organization level denominators are too low to provide reliable results
  - Use of composite does not ameliorate problem

Episode-Based Measures

Finding: Data limitations and small numbers issue affect usability

	Episode Type	Percent of Cost	Percent of POs with 30+ Episodes
1	Diabetes Mellitus Type 2 and Hyperglycemic States Maintenance	5.6%	84.9%
2	Renal Failure	5.5%	37.0%
3	Essential Hypertension, Chronic Maintenance	4.5%	88.5%
4	Angina Pectoris, Chronic Maintenance	4.3%	66.7%
5	Neoplasm, Malignant: Breast, Female	3.2%	39.1%
6	Delivery, Vaginal	2.5%	63.5%
7	Osteoarthritis, Except Spine	2.3%	77.6%
8	Asthma, chronic maintenance	2.2%	77.6%
9	Other Arthropathies, Bone and Joint Disorders	2.0%	88.0%
10	Human Immunodeficiency Virus Type I (HIV) Infection	1.7%	15.1%
11	Rheumatoid Arthritis	1.5%	39.6%
12	Neoplasm, Malignant: Colon and Rectum	1.4%	18.8%
13	Delivery, Cesarean Section	1.4%	34.4%
14	Other Inflammations and Infections of Skin and Subcutaneous Tissue	1.2%	90.1%
15	Other Gastrointestinal or Abdominal Symptoms	1.1%	85.9%
16	Complications of Surgical and Medical Care	1.1%	47.9%

IHA Total Cost of Care Measure

- Description: Total amount paid to any provider to care for all members of a physician organization (PO) for a year
  - Professional, facility (inpatient & outpatient), pharmacy, ancillary costs
  - Capitation, fee-for-service, member cost share, admin. adjustments
- Outliers: Costs above $100,000 per member per year truncated
- Risk adjustment: Concurrent DCG Relative Risk Score with $100K truncation adjusts for age, gender, and health status
- Other adjustment: CMS Hospital Wage Index derived Geographic Adjustment Factor for geographic pricing differences
- Exclusions:
  - Mental health and chemical dependency services
  - Acupuncture and chiropractic services; dental and vision services
  - P4P quality incentive payments
- Very similar to HealthPartners measure

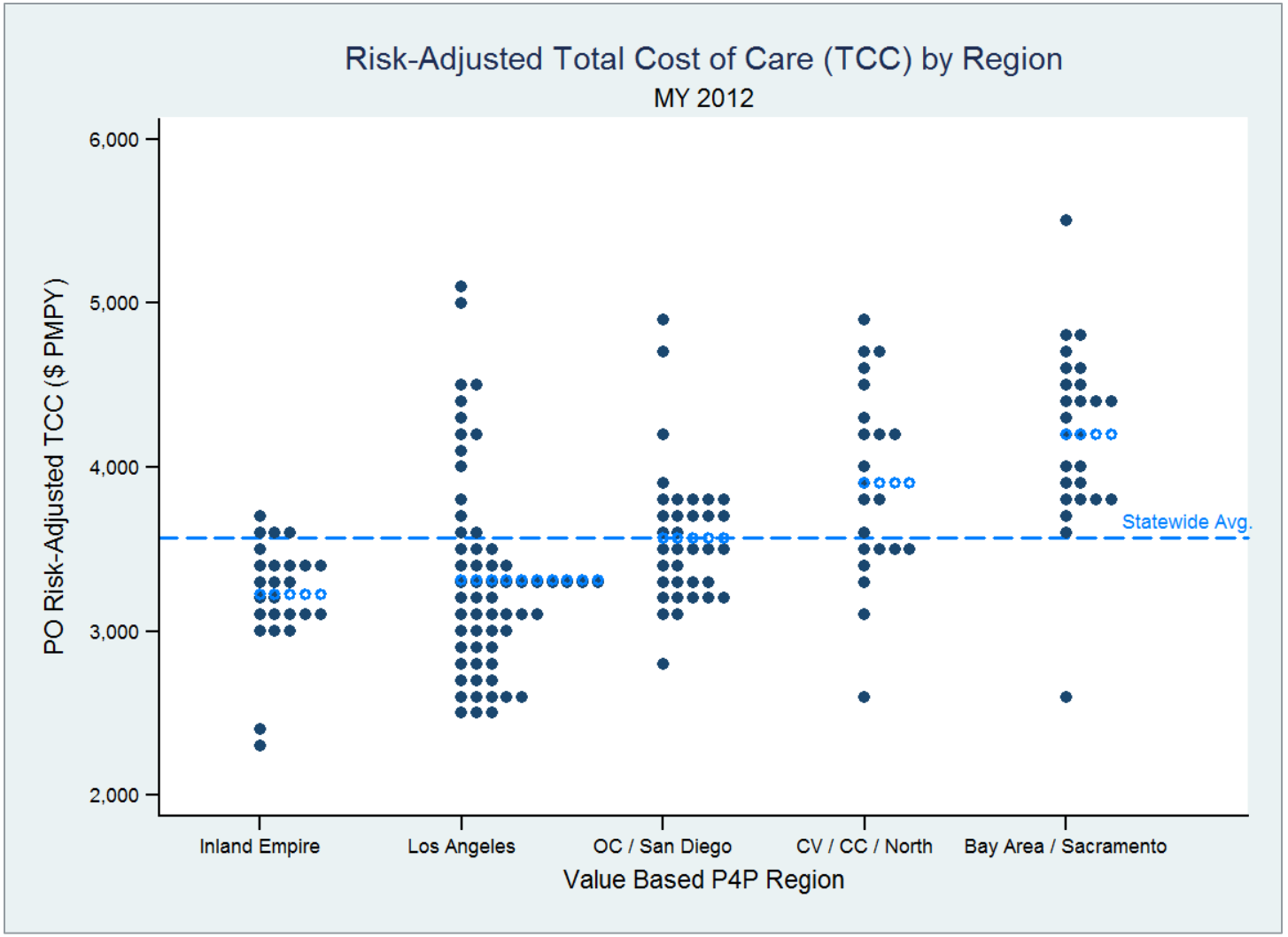
IHA Appropriate Resource Use Measures

- Inpatient Utilization – Acute Care Discharges, Bed Days, Average Length of Stay
- Maternity Utilization – Discharges, Average Length of Stay, C-Sections, VBAC
- Inpatient Readmissions Within 30 Days
- Emergency Department Visits
- Outpatient Procedures Utilization – Percentage Done in a Preferred Facility
- Generic Prescribing
  - Antimigraine
  - Anti-Ulcer
  - Anxiety/Sedation—Sleep Aids
  - Cardiac—Hypertension and Cardiovascular
  - Diabetes
  - Nasal Steroids
  - SSRIs/SNRIs
  - Statins
  - Overall
- Frequency of Selected Procedures
  - Back Surgery
  - Total Hip Replacement
  - Total Knee Replacement
  - Bariatric Weight Loss Surgery
  - PCI
  - Carotid Catheterization
  - CABG
  - Cardiac Endarterectomy

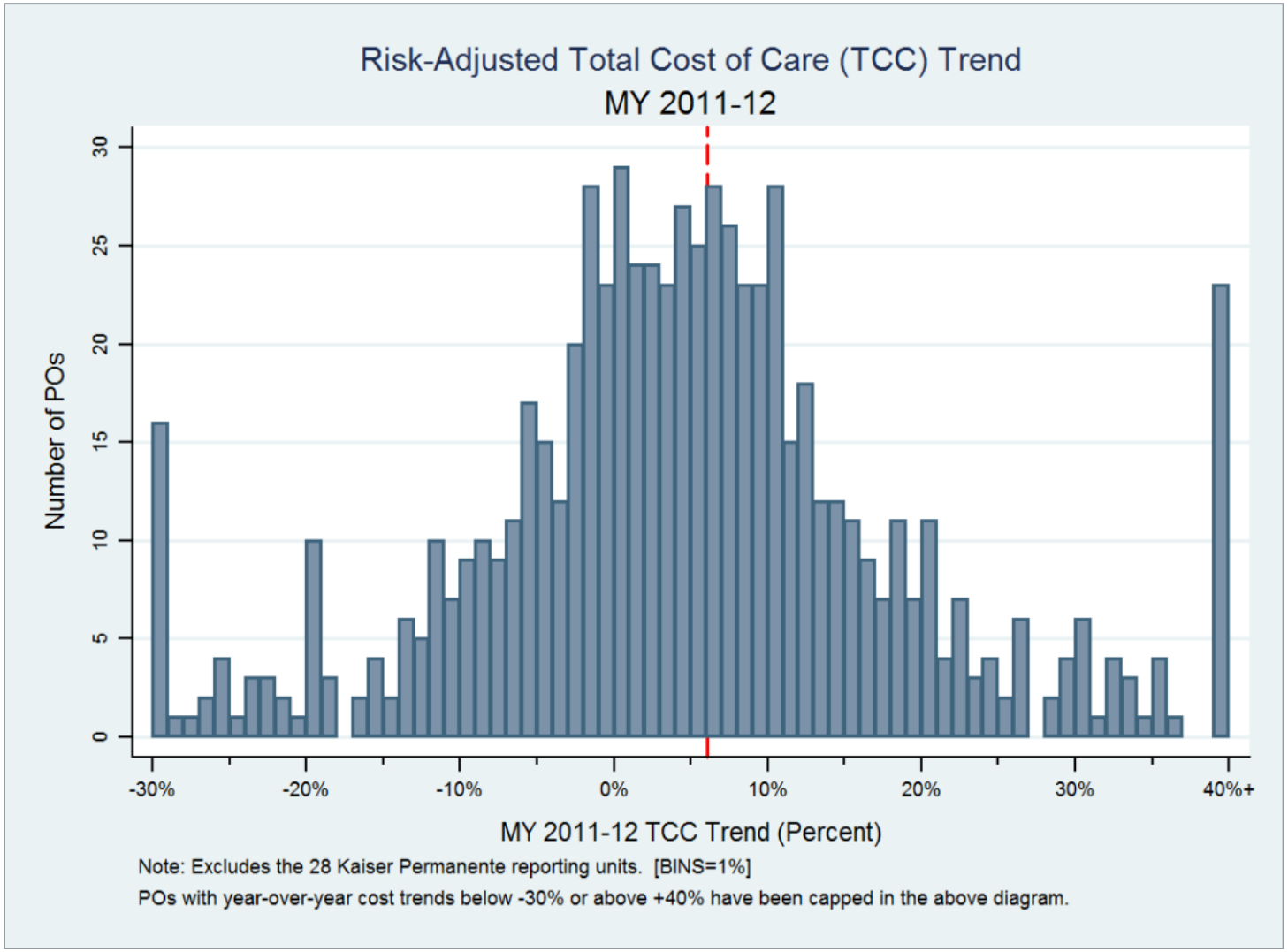
Total Cost of Care in California

Region	POs	MY 2012 Member Years	MY 2012 Average TCC	MY 2011 Average TCC	2011-2012 Average TCC Trend
Bay Area, Sacramento	26	586,677	$4,226	$4,042	4.5%
Central Coast, Central Valley, North	22	248,447	$3,871	$3,651	6.0%
Inland Empire	25	334,218	$3,226	$3,139	2.8%
Los Angeles	61	833,704	$ 3,524	$3,225	9.3%
Orange County, San Diego	35	559,050	$3,670	$3,605	1.8%
P4P Population	***169***	***2,562,096***	***$3,711***	***$3,533***	***4.9%***

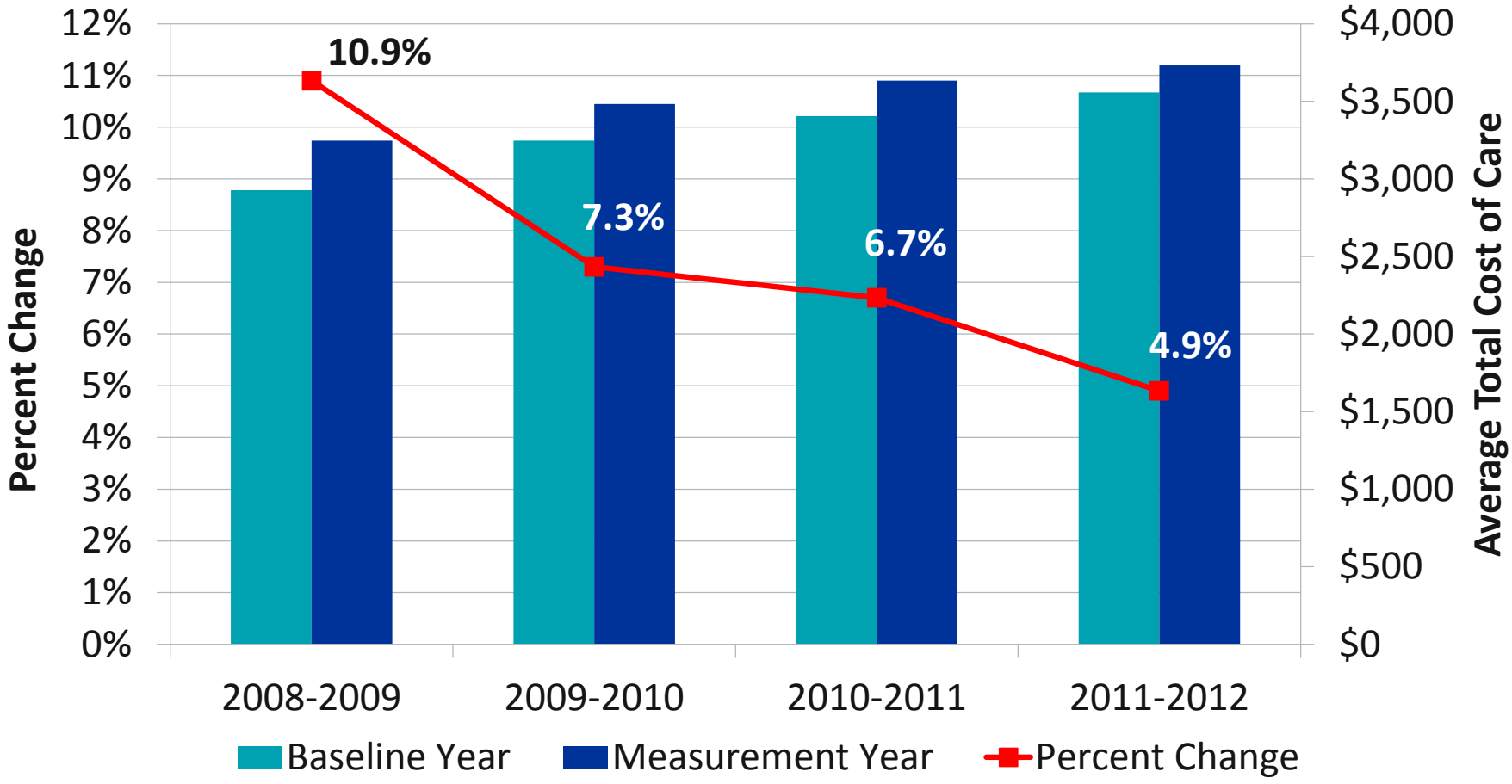
CA Total Cost of Care Regional Variation



CA Total Cost of Care Trend

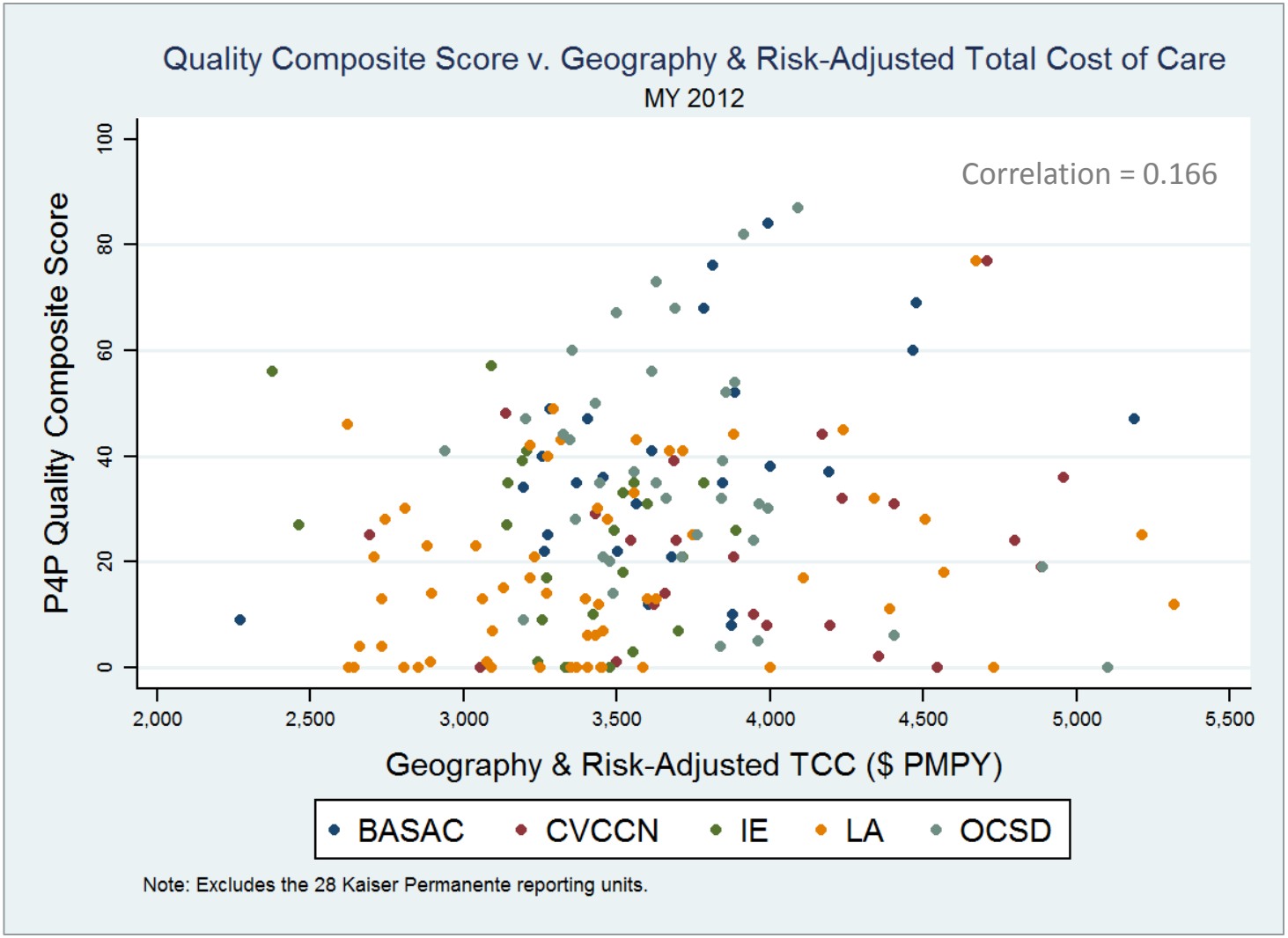


CA P4P Population TCC Results
Change in Average Costs, 2008 - 2012



Note: Changes to plan data and measure methodologies may affect comparisons across years

CA Total Cost of Care vs. Quality



Q&A

2. Moving Toward Efficiency & Value Measurement

Getting to Efficiency: Project Scope

Measuring efficiency presents special challenges as there is currently no standardized and transparent way to assess cost in the context of quality. With funding from the Robert Wood Johnson Foundation (RWJF), and the guidance of an expert panel, the National Quality Forum (NQF) will produce a white paper exploring:

- The current approaches in the field used for measuring and understanding efficiency
- The methodological challenges to linking cost and quality measures for an efficiency signal
- Best practices for combining cost measures with clinical quality measures to assess efficiency of care
- The white paper produced through this work of this project will provide guidance and a pathway toward efficiency measures that matter.

Getting to Efficiency: Work to Date

- The Expert Panel had a web meeting to provide preliminary input on the white paper outline.
- The Panel discussed the challenges of defining cost and the need to consider the implications of the difference between inputs used, prices, and payments as well as the challenges of limited data on measurement based on inputs and prices.
- The Panel reiterated that different stakeholders may have different perspectives on efficiency and the need to separate value from efficiency.

Getting to Efficiency: Linking Cost and Quality Project Timeline

Meeting	Date/Time
Distribution of in-person meeting materials and draft white paper	April 24, 2014
In-person meeting	May 1, 2014 8:30 AM – 5:00 PM ET May 2, 2014 8:30 AM – 3:00 PM ET
Public comment period	May 23, 2014-June 23, 2014
Call to review comments on draft white paper	July 24, 2014, 2:00 PM – 4:00 PM ET
Consensus Standards Approval Committee (CSAC) Meeting	August 12, 2014, 3:00-5:00 PM ET

Getting to Efficiency: Key Questions

Several critical questions on moving to efficiency measures remain, such as:

- What are the various approaches to linking cost and quality signals?
- What are the technical challenges to linking cost and quality signals?
- What are the challenges for actionability?
- How can the results of linked cost and quality measures be used for accountability applications?

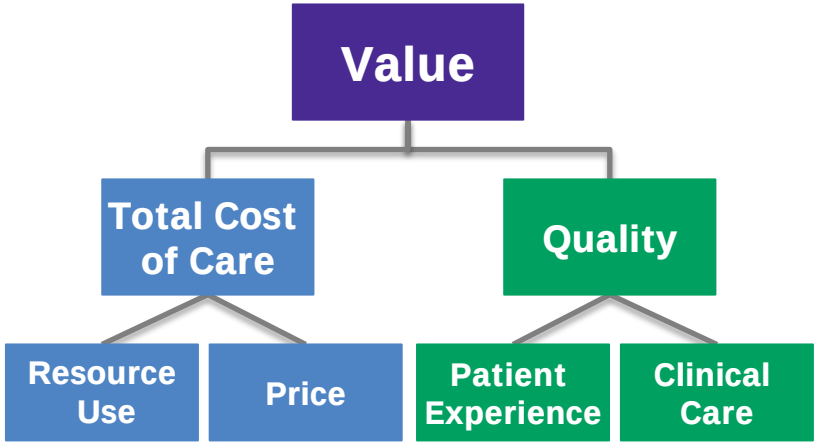
Lessons from the Field

- What are the best approaches to bring together cost and quality information?
- How can we provide information to consumers and purchasers on how to combine these signals to chose the most efficient providers?

HealthPartners Value Model

Optimized Stewardship plus Optimized Quality

- Used for benefit design and transparency
- Providers must be high quality & lower cost to quality as “tier 1”



BENEFIT LEVEL	QUALITY Rating	COST Rating	
Level 1 (“Tier 1”)	★★★★	$	Quality index 33% above average, Cost index 10% better than average
	★★★	$$	Quality index above average, Cost index better than average
Level 2 (“Tier 2”)	★★	$$$	Quality index lower than average, Higher than average Cost
	★	$$$$	Quality index 33% or more below average, Higher than average Cost by 10% or more

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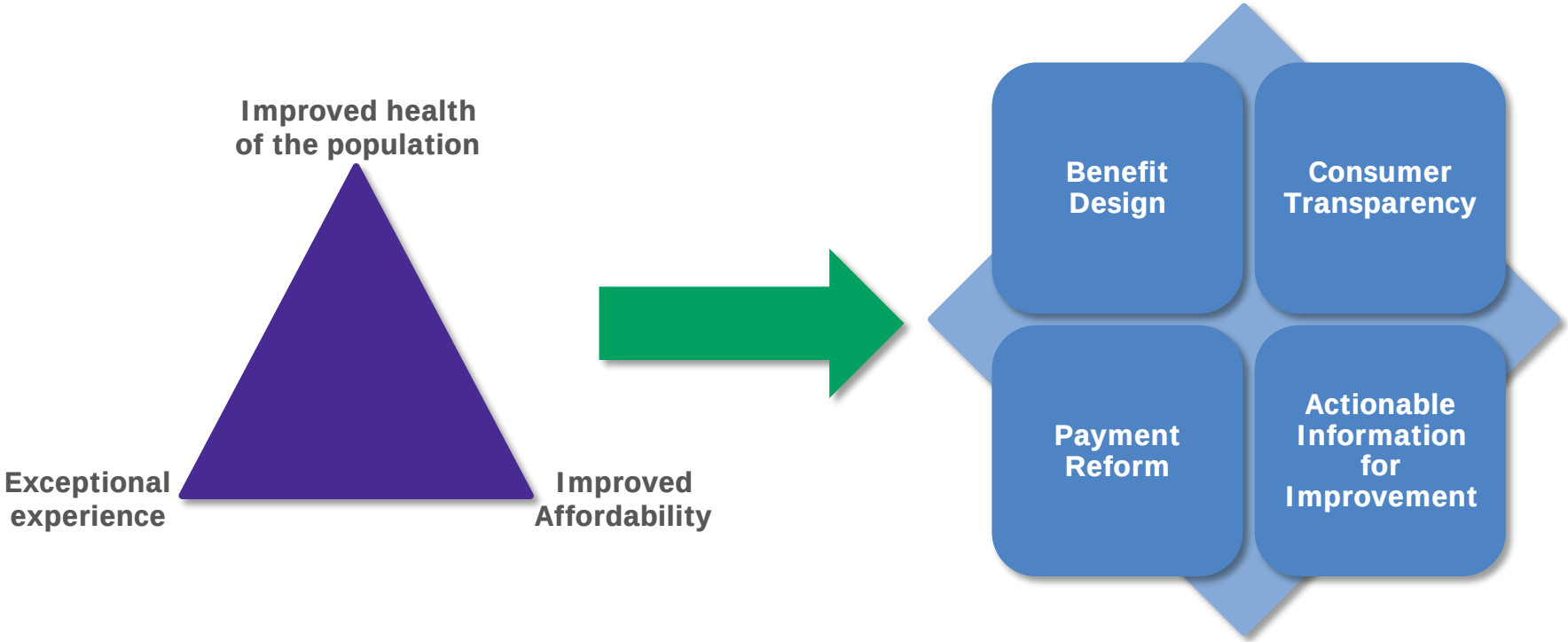
A Triple Aim Approach to Measurement and Use

- Total Cost of Care complements the robust standard measures of quality and patient experience.



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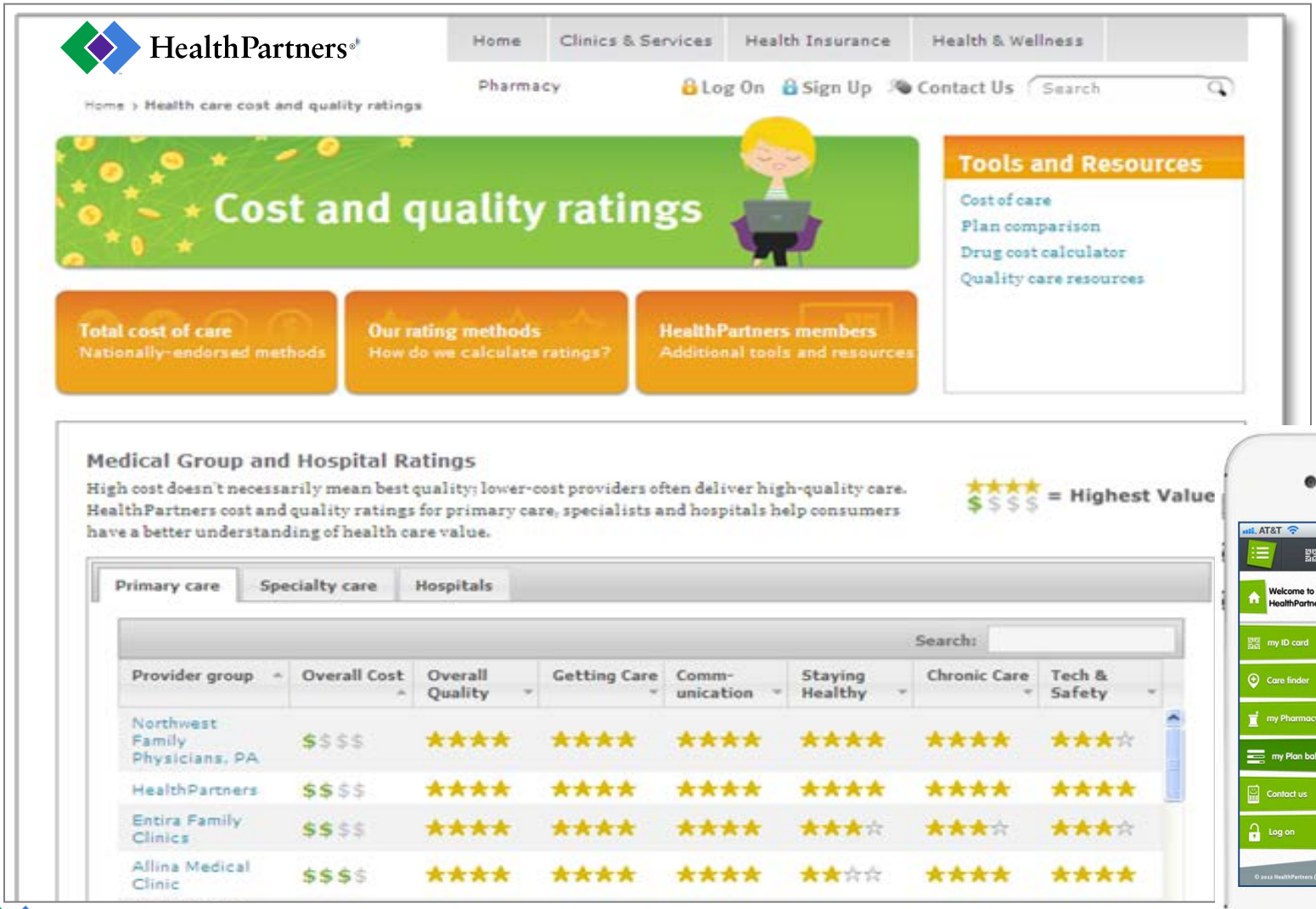
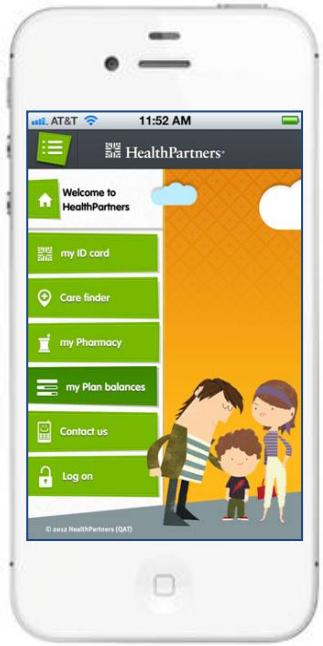
Web and Mobile Transparency





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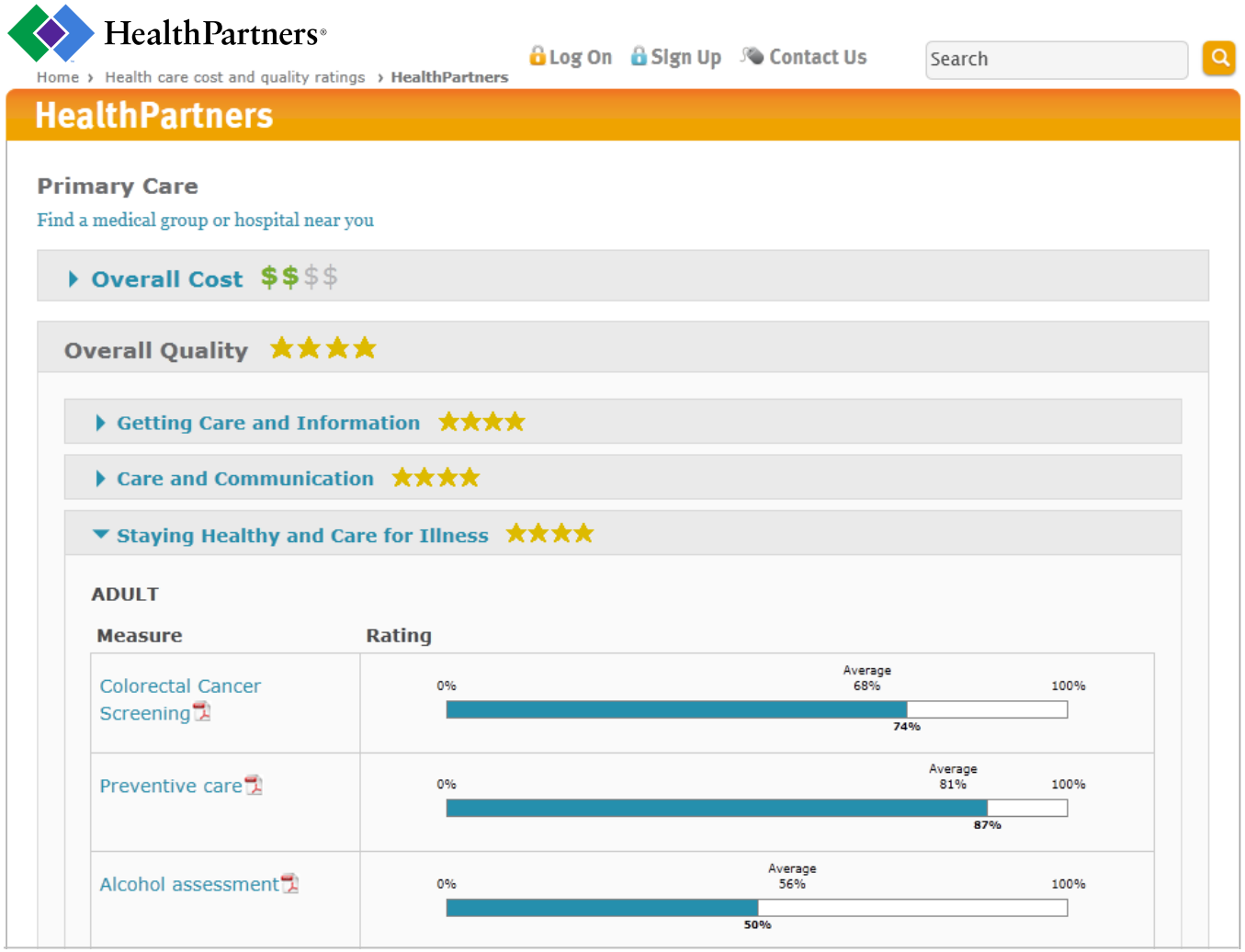
www.healthpartners.com/costandquality

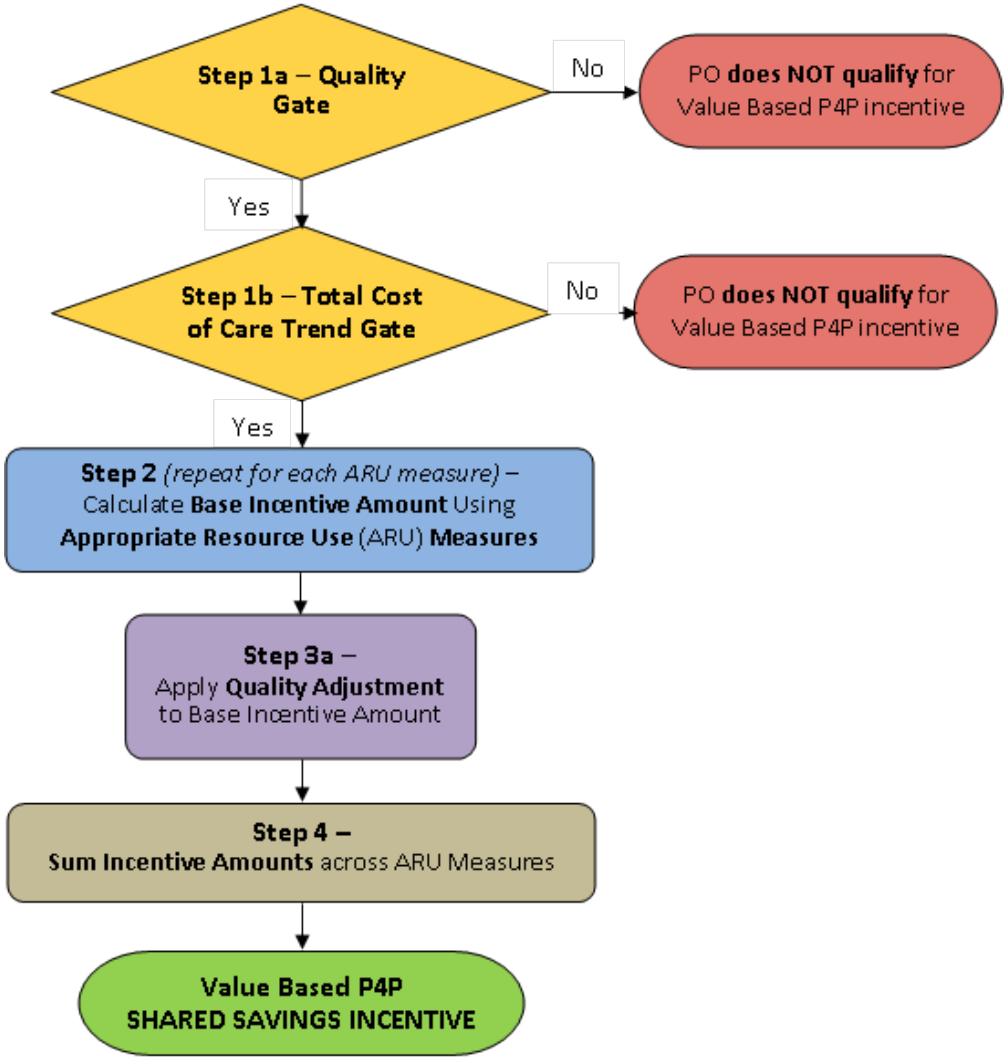
Consumer Transparency



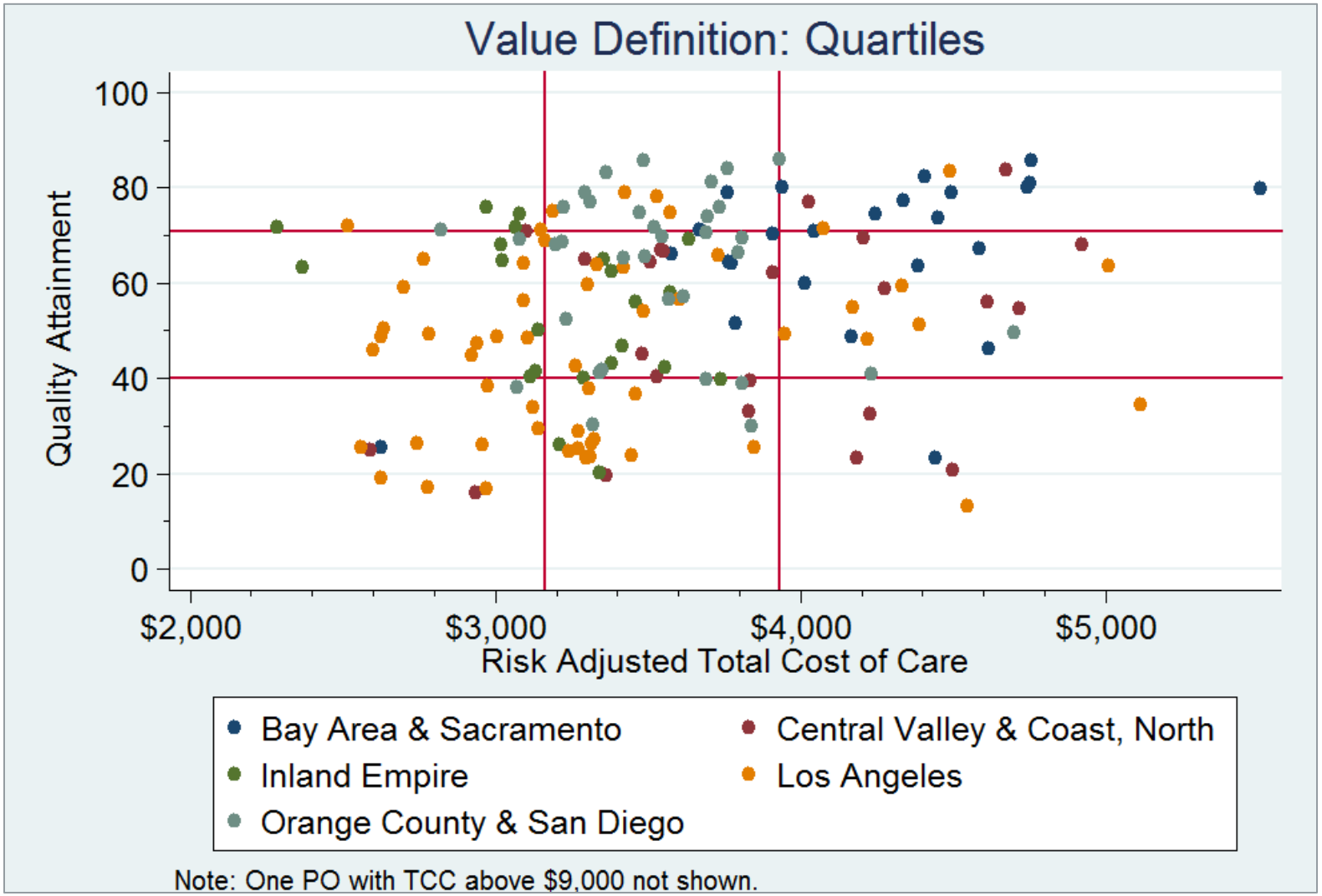
IHA Focus on Incentivizing Value

1. Value Based P4P
   - Single incentive program that incorporates quality, utilization, and total cost
2. IHA recognition of high value physician organizations
3. Public reporting of value
4. Development of value tiers within networks
   - Value based benefit design efforts by health plans and employers to engage consumers in making value based healthcare decisions

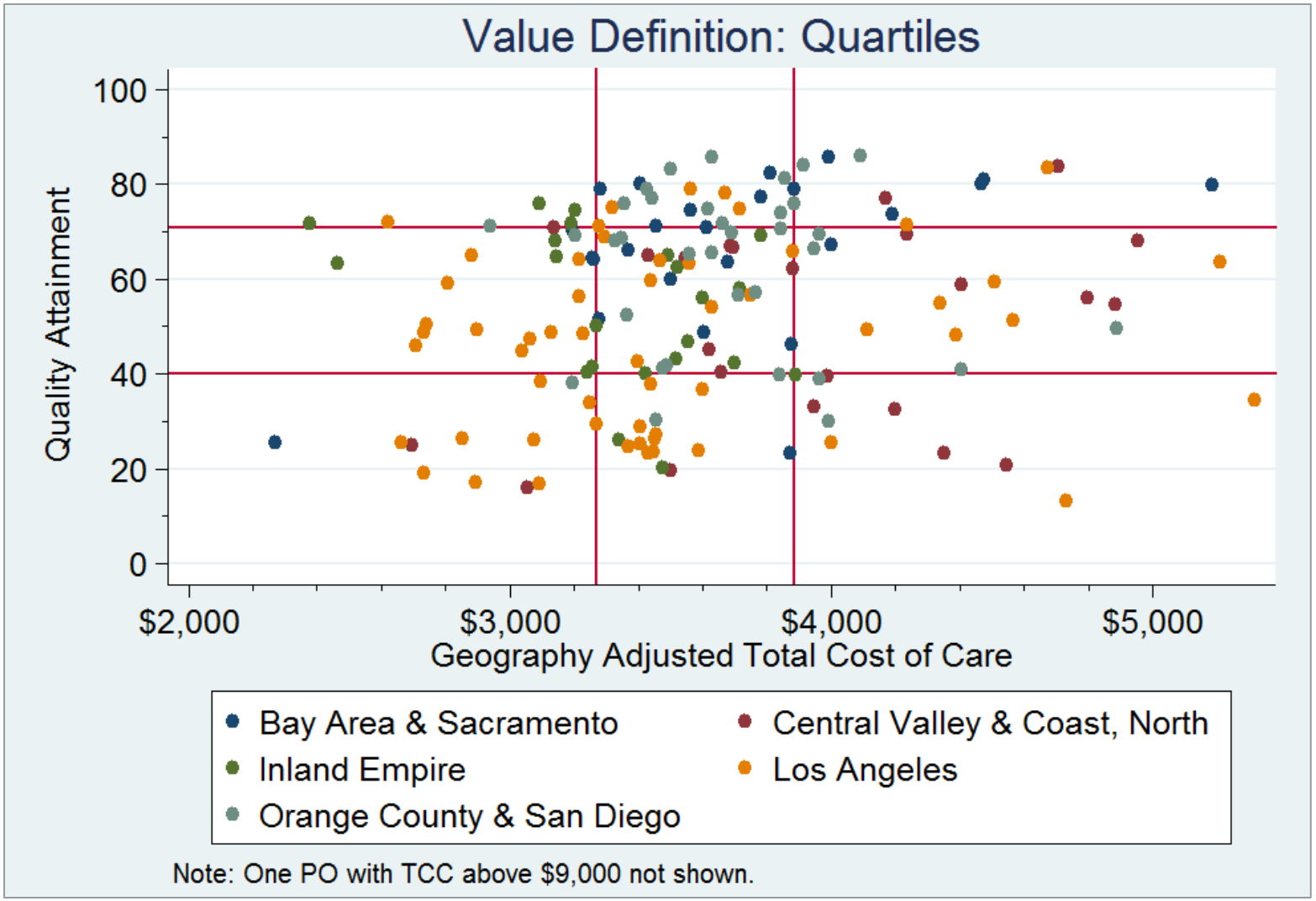
IHA Value Based P4P Core Design



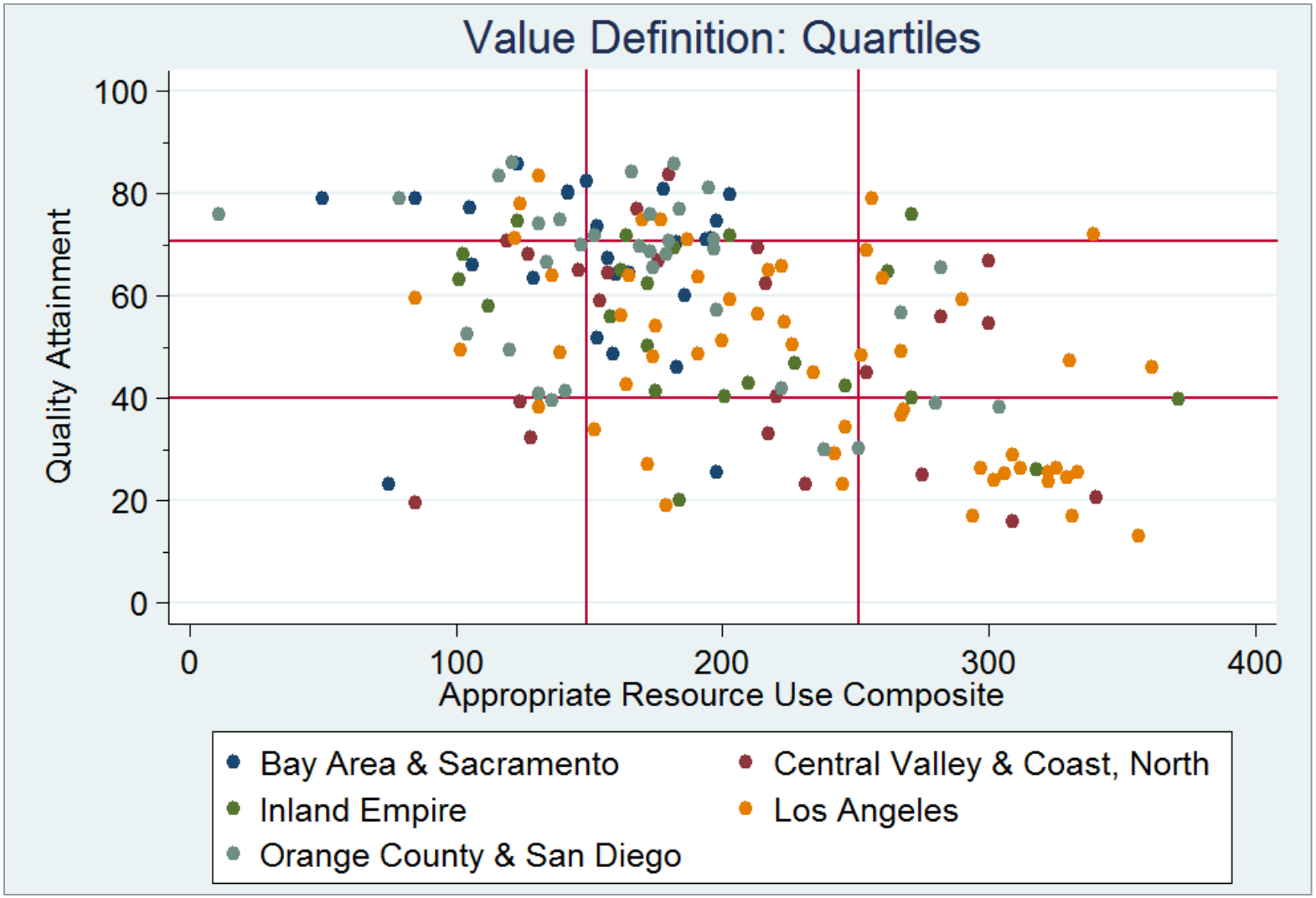
Defining Value – Cost and Quality



Defining Value – Geography Adjusted Cost and Quality

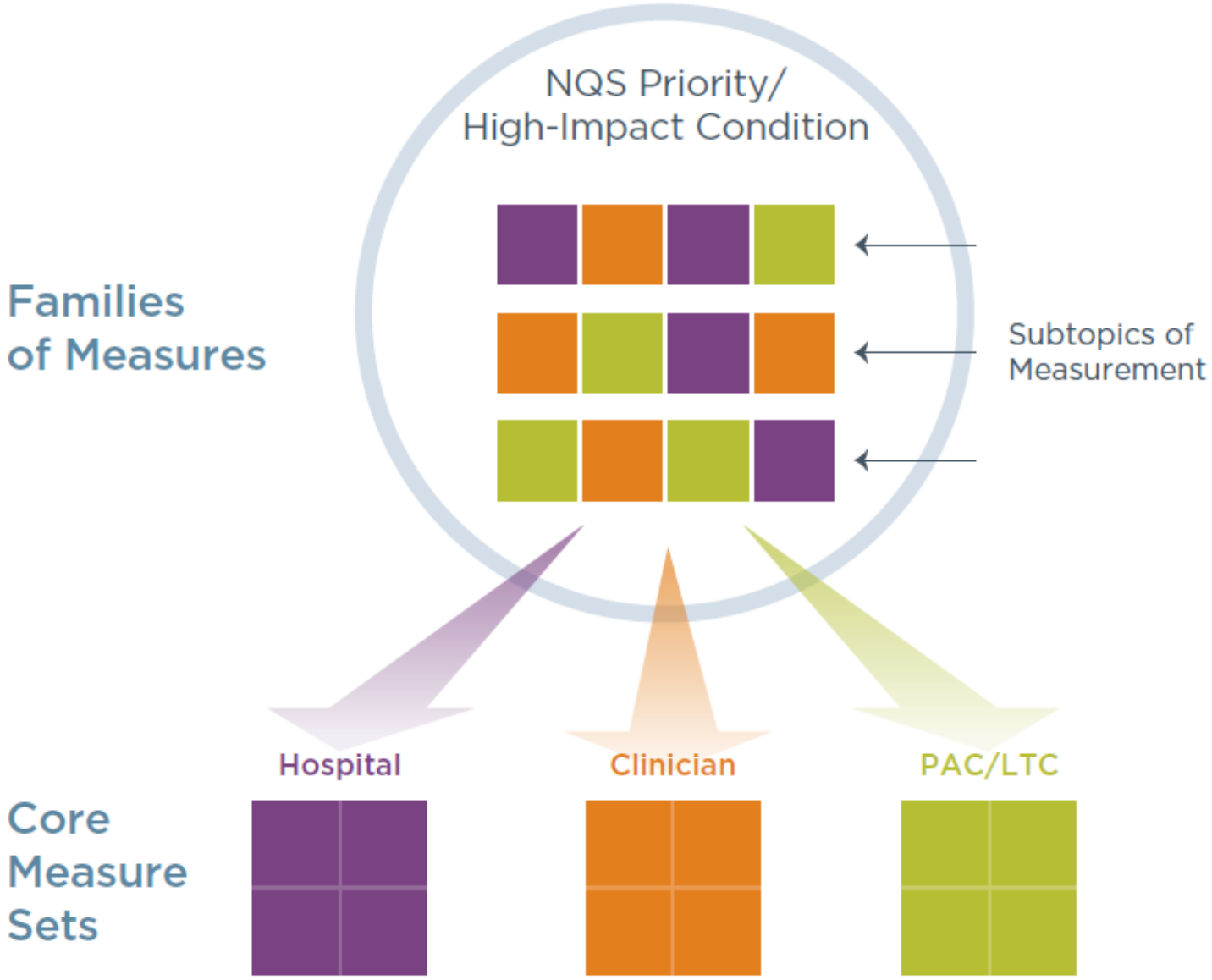


Defining Value – Utilization and Quality

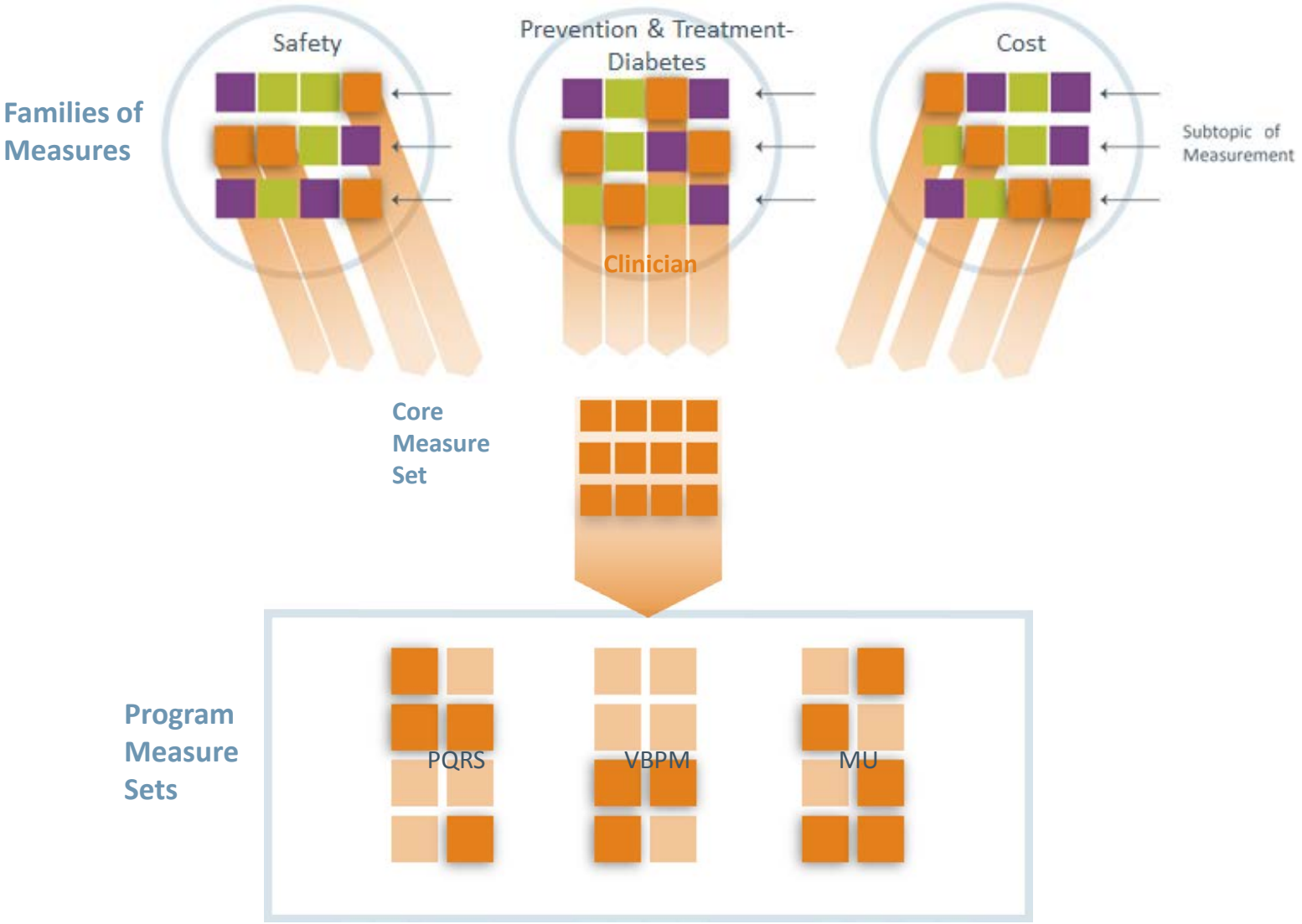


Q&A

3. Aligning Performance Measurement Across the Public and Private Sector



Families of Measures Populating a Core Measure Set



Lessons from the Field

- What are the practical challenges to aligning measures across private sector programs, aligning across public and private sectors?
- What is the path forward to reducing measurement burden?

Alignment across private and public sectors

Challenges:

- Variation in measurement definitions
- Risk adjustment
- Volume of measures
- Lack of specialty measures

Solutions:

- Use a standardized operational model regardless of the financial model
- Look for directional consistency to take action on improvement
- Focus on a small, but meaningful set of measures

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Alignment Across Public and Private Sectors

- Goals
  - Alignment with what plans and providers already required to measure
  - Alignment across products, care settings, time
    - Commercial HMO, Medicare Advantage, Managed Medi-Cal
    - Health plans, physician organization, hospital, ACO
  - Robust measure set
- Challenges
  - Not all measures are applicable for all products
    - Different reporting requirements; different timing for changes
  - Few measures bridge care settings
    - Readmissions, maternity
- Approach: start with what we have and build over time

Discussion