

Multistakeholder Collaborative Leads Initiative on Health Care Quality Measurement

Frequently Asked Questions:

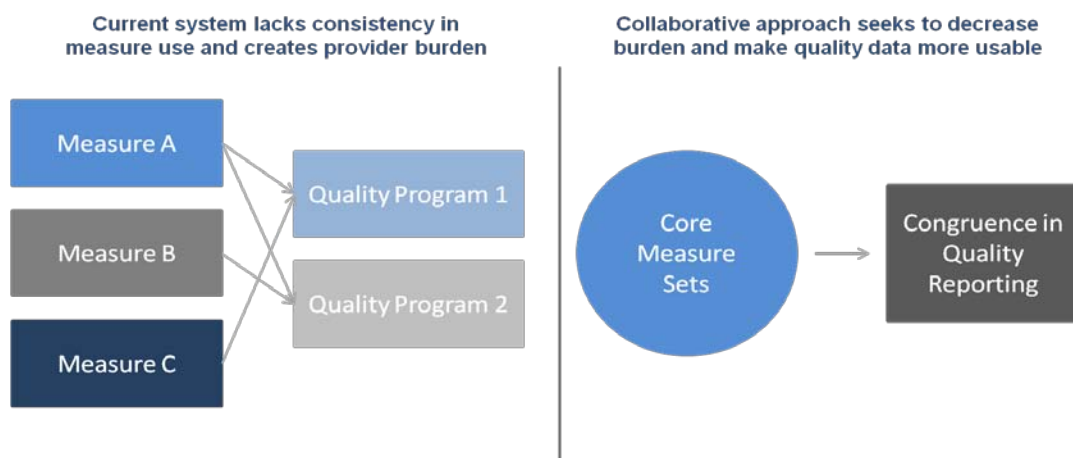
What is the goal of the Collaborative?

Answer:

There is a great demand today for accurate, useful information on health care quality that can inform the decisions of consumers, employers, physicians and other clinicians, and policymakers. This is increasingly important as the health care system moves toward value-based reimbursement models.

It is difficult to have actionable and useful information because so many measures of quality are being used that are not necessarily consistent with each other. This places administrative burden on clinicians and creates confusion among consumers when selecting clinicians.

For the past decade, numerous stakeholder groups have worked to reach consensus on common or core performance measures. While some progress has been made, the movement to new payment models has increased the demand for core measures. Recently, the Centers for Medicare and Medicaid Services (CMS) has worked to align measures across public programs, thereby providing an opportunity to reduce complexity for clinicians and the cost burden on society, as well as to ensure consistent high-quality care for patients. The goal of this effort is to establish broadly agreed upon core measure sets that are aligned and harmonized across public and private payers (CMS and private health plans), add focus to quality improvement efforts, reduce the reporting burden of quality measures, and offer consumers actionable information when making decisions about their care. Such an effort requires the input and participation of CMS, health plans, physician specialty organizations, employers, and consumers.



The collaborative is working principally on establishing core measure sets and consistency in the

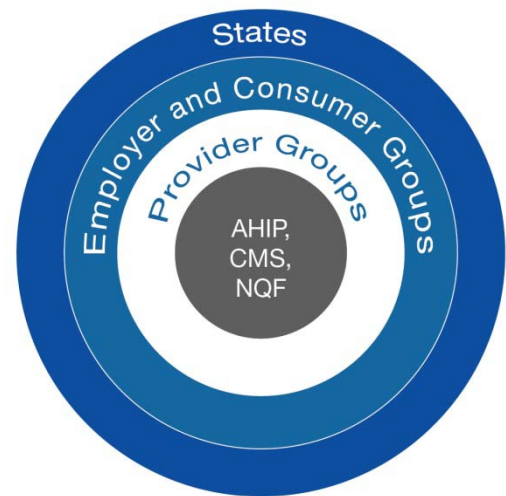
use of measure specifications.

Question:

What is the Collaborative's approach to achieving a core measure set?

Answer:

America's Health Insurance Plans convened leaders from health plans², CMS, the National Quality Forum (NQF), physician specialty societies, employers, and consumers with the goal of collaborating on the development of a core set of measures in selected clinical areas. These discussions, which occurred in a step-wise fashion, established a framework of principles and identified select practice areas for consensus core sets to include: ACO & PCMH/Primary Care, Cardiology, Medical Oncology, HIV & Hepatitis C, Gastroenterology, Orthopaedics, Obstetrics and Gynecology, Pediatrics, and Patient Experience/Patient Reported Outcomes. The Collaborative includes physician groups and professional organizations such as the American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American College of Cardiology, American Heart Association, American College of Physicians, American Gastroenterological Association, HIV Medicine Association, Infectious Diseases Society of America, American Academy of Pediatrics, American Society of Clinical Oncology, Council of Medical Specialty Societies, CAPG, and the American Medical Association. Employers and consumers such as the Pacific Business Group on Health, Memphis Business Group on Health, National Partnership for Women and Families, AARP, and National Patient Advocate Foundation, and regional collaboratives such as the Wisconsin Collaborative for Healthcare Quality and Minnesota Community Measurement, are also participants in the Collaborative and have provided their input and recommendations.



For each of the identified practice areas, workgroups were established. Each workgroup reviewed measures currently in use by CMS and health plans, as well as measures that are endorsed by NQF. Based on this review and discussion, a consensus core set was identified by the workgroups for the selected clinical areas. This consensus core set was further discussed by all Collaborative members before being finalized.

Question:

What criteria were used to select the core set of measures?

² Aetna, Anthem, Blue Care Network, Blue Cross Blue Shield of Massachusetts, Cambia Health Solutions, Cigna, Group Health Cooperative, Harvard Pilgrim Health Care, Health Care Service Corporation, HealthPartners, Highmark, Humana, Inc., Kaiser Permanente, the AmeriHealth Caritas Family of Companies, UnitedHealth Group, and BlueCross BlueShield Association.

Answer:

The Collaborative has developed a framework of aims and principles that informed selection of the core measure sets. These criteria include:

Aims

Recognize high-value, high-impact, evidence-based measures that promote better patient health outcomes, and provide useful information for improvement, decision-making and payment.

Reduce the burden of measurement and volume of measures by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and quality measure reporting requirements across payers.

Refine, align and harmonize measures across payers to achieve congruence in the measures being used for payment and other accountability purposes.

Proposed Principles

Measure sets must be aimed at achieving the three-part aim of the National Quality Strategy: better care, healthier people and communities, and more affordable care.

NQF-endorsed measures are preferred. In the absence of NQF endorsement, measures must be tested for validity and reliability in a manner consistent with the NQF process, and may have been published in a specialty-appropriate peer-reviewed journal and have a focus that is evidence-based.

Data collection and reporting burden must be minimized.

Measure sets for clinicians should be as parsimonious as possible and should focus on those measures delivering the most value.

Measures should be meaningful to and usable by consumers, physicians, other clinicians, purchasers and payers, and also applicable to different patient populations.

Measures that are currently in use by physicians, including those reported through PQRS qualified clinical data registries, measure patient outcomes, and have the ability to drive improvement are preferred.

Measure sets should provide a comprehensive picture of quality, patient-centered care, chosen from the existing measurement landscape to address outcomes of care, overuse, and underuse.

Overuse and underuse measures should both be included as well as total cost of care measures, where appropriate, that are tested and feasible for implementation.

Priority should be given to measures that reflect cross-cutting domains of quality (e.g., patient experience with care, patient safety, functional status, managing transitions of care, medication reconciliation).

Patient outcomes measures should be evidence-based and should focus on those areas where the potential to improve health outcomes and increase the effectiveness and efficiency of care is greatest.

As with all measures, those which assess performance in payment and delivery reform models should be evidence-based, apply at the appropriate level of analysis, and strive to measure on achievement of the Triple Aim of improving clinical quality, patient experience, and lower cost.

³ NQF measure evaluation criteria include: 1. Importance to measure and report (i.e., evidence, performance gap, and priority), 2. Scientific acceptability of measure properties (i.e., reliability and validity), 3. Feasibility, 4. Usability and use, and 5. Related and competing measures.

³ Examples include: Patient experience of care, patient safety, functional status, managing transitions of care, and medication reconciliation.

The core measure sets will be revised and maintained on an ongoing basis by the Collaborative. The Collaborative will continue to develop a process to ensure measure sets reflect the most up-to-date evidence base. For example, measures currently being discussed by the AAOS Performance Measure Committee will be brought to the Collaborative for consideration in 2016.

Question:

How will these measures be implemented?

Answer:

CMS has been working to align measures across public programs. They intend to include, for broad input, the agreed upon draft measure sets in the Physician Fee Schedule and other Proposed Rules. For measures that are not currently in CMS programs, CMS would go through the annual pre-rulemaking and rulemaking processes to solicit stakeholder and public input. Depending on public response, these measures will be included in a timeframe determined by the Agency.

Private health plans will use a phased-in approach to implementation. Such a phase-in will be determined by certain specific factors. Contracts between physicians and private payers are individually negotiated and therefore come up for renewal at different points in time depending on the duration of the contract. Private payers will therefore implement these core sets of measures as and when contracts come up for renewal or if existing contracts allow modification of the performance measure set.

Several of the measures included in the core set require that clinical data be extracted from EHRs or registries or be self-reported by clinicians. While some plans and clinicians may be able to exchange certain clinical data, a robust infrastructure to collect data on all the measures in the core set does not exist currently. The implementation of some measures in the core set will depend on availability of such clinical data either from EHRs or registries. Clinicians and payers will need to work together to create a reporting infrastructure for such measures.

Given ongoing local and regional efforts for quality improvement, clinician performance on some of the measures in the core sets may be topped out in particular areas in the country or within a particular clinician's patient population. Private payer-clinician collaboration will help determine the appropriate subset of core measures for implementation purposes.

Finally, there are specific markets in the United States that have made great progress toward measurement, and in such markets, payers will continue to work in collaboration with clinicians to implement new and innovative measures. Such an approach can help advance quality measurement and improvement.

Self-insured employers, as well as individual states as the responsible fiduciary agent, may consider other measures.

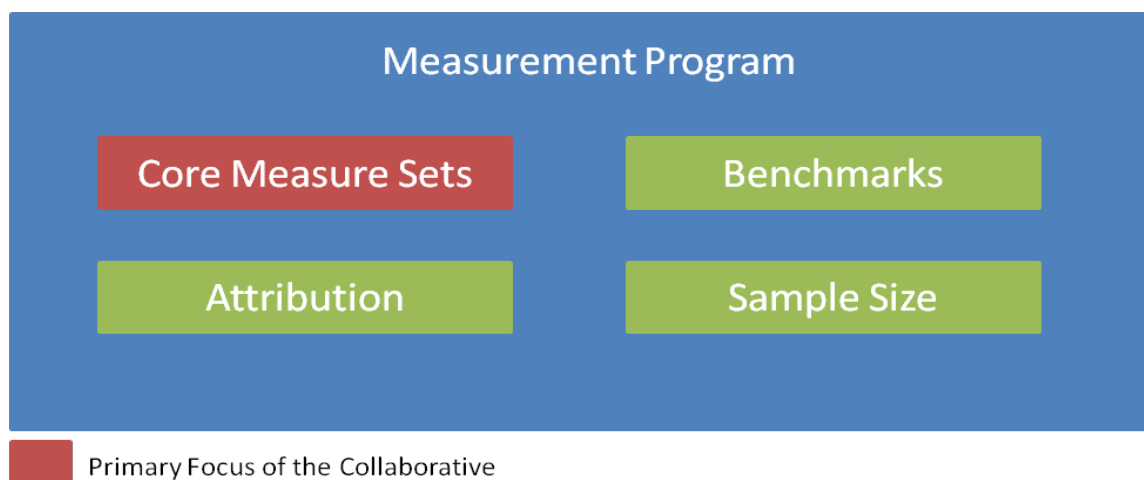
The Collaborative will work with the multi-stakeholder Healthcare Payment Learning and Action Network (LAN)⁴ established by CMS to integrate the core measures into alternative payment models as part of overall alignment of payment methods. The Collaborative will also work on developing a process to help track progress toward measure alignment in the public and private sectors.

Question:

How do the core quality measure sets relate to other key components of measurement programs?

Answer:

The primary focus of this Collaborative is to achieve consensus on a core set of measures and measure specifications, and establish a process through which continual refinement and modifications to the core set can occur. The Collaborative recognizes that the core quality measures are components of a broader measurement program that includes the following key topic areas: patient attribution, sample size to ensure reliable reporting, risk adjustment, data collection and transparency, and establishment of performance benchmarks. These important areas will be addressed by the Collaborative participants either through the rule-making process for CMS or for private payers through discussions and negotiations between clinicians and health plans. In addition, the multi-stakeholder Healthcare Payment Learning and Action Network (LAN) established by CMS and the National Quality Forum's measurement science projects (i.e., attribution, adjustments for socioeconomic status pilot) are working to identify common approaches to some of these important areas such as attribution. Several of the Collaborative's members are actively engaged in these discussions and we hope to be able to learn from LAN and NQF activities and rely on the guidance issued.



⁴ <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>

We have outlined below a high-level description of how private payers and CMS currently approach attribution, sample size, and benchmarking.

Attribution: The goal of attribution is to ensure that the approach used to assign accountability is reflective of the patient-clinician relationship. Models of attribution in the private sector typically rely on a patient's history with a particular clinician in order to assign accountability to that clinician. Attribution is usually visit-based and also depends on a majority or plurality rule - i.e., the patient receives the majority or plurality of the care from a particular clinician. The types of visits that are typically used for attribution purposes are evaluation and management visits. The specific threshold for establishing such plurality can vary across payers. In alternative payment and delivery models such as ACOs/PCMH and bundled payments, lists of attributed patients are reviewed and reconciled during the term of the contract to help more accurately reflect the patient-clinician relationship. In addition to attribution to primary care physicians and clinicians, private payers also attribute patients to the relevant specialists and/or sub-specialists where the accountable physician is also established using rules described above.

Attribution rules for Medicare are determined by CMS and include seeking public input through the notice and comment rule-making for each quality or value-based purchasing program.

Sample Size: Reliability and validity of clinician performance measurement depends on having an adequate sample of patients that meet the inclusion criteria of a particular measure. To avoid small numbers issues, private payers use approaches such as establishing minimum sample sizes, as well as incorporating measures of precision for an estimate and computed statistic, such as the confidence interval around a result.

Benchmarks: Establishing quality benchmarks relevant to measurement is central to the goal of continuous quality improvement in healthcare. Private payers typically establish benchmarks using data across all clinicians within a specific geographic area. Benchmarks allow clinicians to compare themselves to their peers. In addition to calculating performance benchmarks for quality measures, private payers also use statistical tests of significance to ensure that meaningful differences in performance can be discerned. Private payers also discuss the methods for establishing realistic benchmarks and selection of actual benchmarks with their clinician partners, knowing that 100 percent compliance on every measure may not be appropriate given specific patient risks.

Question:

How will the Collaborative approach retirement of measures?

Answer:

The Collaborative will continue to meet regularly to ensure ongoing measure alignment, which may include updates to the core set based on new measure development, measures that emerge from specialty society performance measures committee process, and retirement of measures.

Measures will be retired based on five criteria:

1. The evidentiary basis for a measure has changed;
2. Sustained high performance on a measure and achievement of a targeted benchmark;
3. Low return on investment (i.e., the cost of collecting and measuring outweighs the utility of the measure); and
4. The measure has been demonstrated to have minimal impact on health outcomes and status.
5. Measures of demonstrated higher-value or higher-impact have evolved and address the same clinical or concept area.

These criteria are similar to those used by other organizations such as NCQA and CMS, and also relate closely to the NQF measure selection criteria. The core measure sets will be revised and maintained on an ongoing basis and the Collaborative will continue to work on a process regarding the retirement of measures.