



Health Program

Health Project

Transitioning from Volume to Value:

Consolidation and Alignment of Quality Measures

April 2015



BIPARTISAN POLICY CENTER



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ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

DELIVERY SYSTEM REFORM INITIATIVE

In April of 2013, BPC issued A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment, a report which laid out a comprehensive set of policy recommendations for lowering costs, improving quality, and reducing inefficiency across the health care system. As a continuation of that work, the Delivery System Reform Initiative's four co-chairs – former Senate Majority Leaders Tom Daschle and Bill Frist, former White House and Congressional Budget Office Director Dr. Alice Rivlin, and former Ranking Member of the House Ways and Means Committee Jim McCrery – are developing meaningful policy solutions to facilitate and accelerate the transition to a value-based health care system.

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This paper was produced by BPC staff, in collaboration with a distinguished group of senior advisors for the Delivery System Reform Initiative. BPC would like to thank Sheila Burke, Stuart Butler, Paul Ginsburg, Chris Jennings, Steve Lieberman, and Tim Westmoreland for providing substantial direction and support, and acknowledge BPC staffers Katherine Hayes, Nancy Lopez, Katie Taylor, Marisa Workman, Katie Golden, and Brian Collins for their contributions in research and writing.

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Background

The Bipartisan Policy Center (BPC) Delivery System Reform Initiative leaders and staff, in collaboration with a diverse set of health care experts and stakeholders, are developing solutions to meaningfully facilitate and accelerate the transition to higher-value, more coordinated systems of health care payment and delivery. This work builds on comprehensive policy recommendations in BPC's 2013 report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*.¹ Since its publication, experts and officials have had nearly two years of additional experience with reformed payment in Medicare, Medicaid, commercial insurance, and self-insured plans. BPC leaders feel strongly that a successful outcome of efforts in this area would improve quality and patient experience as it lowers health care cost growth.

In April 2015, Congress enacted H.R. 2, the Medicare Access and the Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA), a bipartisan legislation crafted by leaders of the congressional committees of jurisdiction (Senate Finance, House Ways and Means, and House Energy and Commerce). This legislation reforms physician payment under Medicare to establish clear incentives within the physician fee schedule for the adoption of alternative payment models (APMs).² MACRA represents an important bipartisan step toward transitioning from fee-for-service payment to new models that reward value, including improved health outcomes, patient experience, and lower cost.

Over the course of the last year, BPC has issued a series of white papers that include recommendations to accelerate the transition from fee-for-service to APMs based on value and to assure that these models are sustainable over time. The recommendations in this series are intended to build on early APM implementation, to improve the viability of APMs, and to make progress toward the long-term vision for the health care system presented in *A Bipartisan Rx*. This is the final of four white papers in the series, which include:

1. *Transitioning from Volume to Value: Opportunities and Challenges for Health Care Delivery System Reform* discusses progress and next steps toward payment and delivery systems that increase provider accountability for health outcomes, patient experience, and cost. [August 2014]³
2. *Transitioning to Organized Systems of Care: Medical Homes, Payment Bundles, and the Role of Fee-for-Service* addresses early implementation of two APMs in Medicare, bundled payment and patient-centered medical homes, as well as adjustments to the Medicare fee schedules. [January 2015]⁴
3. *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare* reviews implementation of

accountable care organizations (ACOs) in Medicare and offers near-term recommendations to improve this model. [January 2015]⁵

4. This paper: *Transitioning from Volume to Value: Consolidation and Alignment of Quality Measures*. The final paper in this series addresses the imperative to have a core set of user-friendly, meaningful, and outcomes-oriented quality measures integrated within all alternative payment and delivery reform models. [April 2015]

Introduction

Over the last year, the Bipartisan Policy Center (BPC) has issued a series of white papers recommending changes in the health care delivery system to improve quality and slow the rate of growth in costs. These recommendations provide incentives for providers and patients to move toward organized systems of care—such as accountable care organizations (ACOs), patient-centered medical homes, and other payment models—and away from fee-for-service. The use of meaningful quality measures is critical to assuring patients have access to and receive appropriate services and that incentives drive improved health outcomes and patient care experience. However, despite discussions and work on this objective, there remains little agreement on which—and how—measures should be used by patient, provider, and payer communities. Effective quality measures are imperative to accountability in organized systems of care, especially where performance affects the ability of the provider to share in savings or determines whether a provider avoids penalties or receives bonus payments. As recommended in *A Bipartisan Rx*, quality-performance measures must be precise and clinically relevant to incentivize better delivery of health care. In fact, these measures must also provide meaningful data that can be adapted and publically reported in a way that consumers would find useful in making health care decisions and that providers would find helpful in designing strategies to improve quality and patient safety.

In attempting to achieve these goals, payers, providers, standard-setting/accrediting bodies, and federal and state agencies have pursued quality metric design, evaluation, and reporting, as well as the identification of a multitude of different quality measures. Much progress has been made over the years to develop meaningful quality measures and the federal government has made progress on aligning quality measures across federal programs. However, many entities have somewhat different perspectives and priorities, which, when combined with ill-defined and overlapping roles and responsibilities, has led to confusion and inefficiencies, including the inability to use the same measures across different health care payers. This inability has led to implementation of numerous, disparate measures leading to provider burden and confusion among consumers. The use of non-standardized (non-endorsed) measures by payers (whether similar endorsed measures exist or not), modification of endorsed measures, and a lack of uniform use of measures further contribute to the confusion and inefficiencies. As discussed in greater detail below, the proliferation of these measures burdens providers and undermines both payers and consumers. Failure to address the shortcomings in quality measurement will impede the shift from fee-for-service to alternative delivery and payment.

In 2013, BPC outlined recommendations for prioritizing, consolidating, and improving the use of quality measures by consumers and practitioners. While some of those recommendations have been adopted, identifying and adopting a limited set of quality measures that can be used across payers has been a long-standing challenge for policymakers and has not been achieved. This paper focuses on recommendations to strengthen the quality-reporting system and the validity of available metrics. BPC encourages the present trend of private and public organizations and relevant stakeholders working together to better align the current measures and agency promulgation of a core set of measures that are clinically relevant and useful to providers, and that can be adapted to be accessible to consumers.

The Development of Quality Measures

In the early 1990s, several significant reports discussed the gravity of the quality problem in America's health care system⁶; however, it was the publication of two reports from the Institute of Medicine (IOM) that brought national attention to the serious need for quality improvement in the U.S. health care system. The first report, *To Err is Human: Building a Safer Health System*, documented safety gaps in health care by noting that up to 98,000 people die every year in hospitals due to preventable medical errors.⁷ The second report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), documented the failure of the health care delivery system to provide "consistent, high-quality medical care to all people."⁸ The *Quality Chasm* report establishes six principal guiding aims in an effort to change the capacity of the health care system to provide quality health care for Americans. These aims are as follows: health care should be safe, effective, patient-centered, timely, efficient, and equitable.⁹ The IOM recommended developing standardized measures related to the six aims, publicly releasing these standardized performance measures in a manner that is meaningful to both providers and consumers, and paying providers based on quality and efficiency.¹⁰

Since IOM's reports, policymakers and stakeholders have sought solutions to improve measurement and reporting on quality in the health care system. Indeed, nonprofit and for-profit organizations started to focus on the definition and measurement of quality and how to collect data on it and use measures to improve it.¹¹ The popularity of using performance measurement to assess quality created active development and promotion of measures and measurement systems, resulting in a wide variety of measures and transparency of performance data.¹²

Key Players in the Development of Quality Measurement

Over the past decade, quality-improvement initiatives, task forces, and reports have been implemented and published. Today, there are federal and state organizations, private entities, trade-associations, nonprofits, and private for-profit organizations that have and continue to develop quality measures. The array of organizations adds to the complexity and frustration of both providers and consumers of health care services. Some of these efforts have been led by the following organizations:

The Joint Commission: a nonprofit organization established in 1951 and charged with providing voluntary accreditation of hospitals based on a distinct set of minimum quality standards. Currently, the Joint Commission accredits and certifies more than 20,000 health care organizations and programs. The Joint Commission convened a Cardiovascular Conditions Clinical Advisory Panel and, in 2001, announced four initial core measurement areas for hospitals, including acute myocardial infarction and heart failure. Collaboration between the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission to work to align these common measures resulted in the creation of one common set of measure specifications documentation known as the *Specifications Manual for National Hospital Inpatient Quality Measures*, which is used by both organizations.¹³ The Joint Commission requires reporting of measures many of which are similar to what CMS requires. Also the Joint Commission is beginning to consider performance of hospitals on select performance measures as an input into accreditation decisions. The majority of funding for the Joint Commission comes from accreditation survey and certification review fees.

Accreditation Association for Ambulatory Health Care, Inc. (AAAHC): a private, independent, nonprofit accrediting organization founded in 1979 and dedicated to promoting and advancing patient safety, quality, value, and performance measurement in ambulatory settings.¹⁴ The AAAHC accredits more than 5,800 ambulatory health care organizations through peer-based accreditation processes. The AAAHC founded the AAAHC Institute for Quality Improvement (the Institute) in 1999. The Institute is a nonprofit organization that educates ambulatory health care organizations on performance measurement, benchmarking, and quality improvement. The Institute receives funding from study participant fees and contributions by interested organizations as well as from unrestricted grants.¹⁵

The Agency for Healthcare Research and Quality (AHRQ): a federal agency created in 1989—today, one of 11 operating divisions of the U.S. Department of Health and Human Services (HHS)—to improve quality, safety, efficiency, and effectiveness of health care.¹⁶ As part of its mission, AHRQ is charged with enhancing public-reporting strategies and developing tools to produce better quality and outcomes. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is an AHRQ initiative that promotes the assessment of consumers' experience with health care.¹⁷ The president requested funding levels of \$479.3 million for FY 2016 (\$223 million for research on how to improve the value, effectiveness, quality, and results of health care services).¹⁸

The National Committee for Quality Assurance (NCQA): a nonprofit organization established in 1990 and charged with managing accreditation programs for individual physicians, health plans, and medical groups.¹⁹ Currently, NCQA measures accreditation performance of health plans through the administration and submission of the Healthcare Effectiveness Data and Information Set (HEDIS) and the CAHPS survey. In 1993, it published its first Health Plan Report Card (using HEDIS), which was the first time it was possible to compare health plans on the effectiveness of care that plan members received.²⁰

NCQA accreditation includes a structural review of the organization's policies and procedures as well as performance measures (HEDIS). To a much greater degree than the Joint Commission, HEDIS performance results are a key determinant of accreditation (but not the only determinant). The NCQA is mostly supported by private and public grants and contracts as well as by corporate sponsors; however, it does not accept corporate sponsorship of measure development.²¹

URAC (originally known as Utilization Review Accreditation Commission): an independent, nonprofit organization, formally incorporated in 1990, whose mission includes improving quality and accountability of health care organizations using utilization-review services (i.e., where organizations determine if health care is medically necessary for a patient). URAC also accredits many types of health care organizations (e.g., health plans, preferred provider organizations, ACOs). Currently, URAC has more than 30 accreditation and certification programs and accredits programs doing business in every state. The URAC governing board of directors is composed of consumers, providers, employers, regulators, and industry experts.²² Roughly half of URAC's revenue comes from accreditation fees and the other half from grants, publication fees, and conferences.²³

The National Quality Forum (NQF): a private nonprofit membership organization formed in 1999 whose mission is to improve the quality of health and the health care system. NQF has more than 400 members including consumer organizations, public and private purchasers, physicians, hospitals, and other relevant stakeholders. Charged with planning an implementation strategy for quality measurement, data collection, and reporting standards throughout the health care community, the NQF's primary role is evaluating measures that other organizations develop and present for endorsement. To date, NQF has endorsed over 600 measures.²⁴ The Affordable Care Act (ACA) assigns new duties to NQF as the consensus-based entity, including convening multi-stakeholder groups to provide input to HHS on the selection of performance measures for more than 20 public reporting and performance-based payment programs. To fulfill this role, NQF has established the Measure Applications Partnership (MAP). About a third of NQF's \$20 million budget is in private dollars, including membership dues, foundation grants, and annual conference revenue. The other two-thirds of NQF's budget comes from federal funding from two separate but now integrated draws on the Medicare Trust Fund.²⁵

Additional Public- and Private-Sector Initiatives: Professional societies—such as the American Heart Association, American College of Surgeons, and American College of Cardiology—and health plans develop measures that may undergo evaluation by the NQF. Payers also develop, test, and submit measures for NQF endorsement. For example, the NQF endorsed a total cost-of-care measure developed by Health Partners. In addition, for-profit companies, such as Healthgrades, have developed measures to use in grading health care providers. However, these measures have not been evaluated by NQF and, thus, researchers question the validity of these "report cards."²⁶ The Leapfrog Group, an employer-based coalition, is one of the types of organizations that publishes a hospital "report card" as well as issues a hospital survey that captures hospital performance in

patient safety, quality, and resource utilization.²⁷ While the overall survey is not endorsed by NQF some of its component parts are endorsed. Currently, the Leapfrog Group assesses more than 1,400 hospitals. States are currently using quality measures to encourage provider accountability; an example is Minnesota, where the Department of Health is required by statute to establish a standardized set of quality measures.²⁸ Minnesota's Health Care Delivery Systems Demonstration, a Medicaid shared-savings accountable care program, is tying eligibility for payments based on savings to performance on a distinct ten measures that are reported as part of the statewide quality-reporting system to ensure quality without creating new reporting.²⁹

Public Reporting and Pay-for-Performance

As stakeholders—including health care providers, payers, and policymakers—became more concerned about quality of care, both public and private payers began to seek ways to incentivize higher quality of care. This shift led to the majority of quality-performance measure data being used for public reporting of provider performance and, more recently, performance-based provider payment (also known as pay-for-performance). Public- and private-sector payers shifted from financial incentives for reporting on quality metrics, to linking reimbursement to quality. Over time, payers and policymakers have blurred the lines on the goal of quality measures. While once considered a patient-safety issue, public and private payers also see quality improvement as a means of controlling health care costs by eliminating unnecessary or harmful care.

Public reporting of quality-of-care measures for the public sector began in the early 2000s (reporting for the private sector began in the early 1990s) with the purpose of enabling patients to make informed health care choices, allowing providers to see what areas need improvement, and providing some accountability to consumers' health care spending.³⁰ While there is evidence the public reporting has spurred quality improvements, there have been studies that show that consumers don't use the reported information when deciding what providers to select, mostly because they are unaware of the information, or the information is not presented in a way that the consumer can easily understand and act upon to guide choice.³¹

Pay-for-performance programs link financial incentive or penalty to the providers' performance on a specific set of quality and cost measures as a way to deliver value instead of volume. Both public and private payers are using these models in an effort to improve quality and to slow the growth in health care spending.³² There are success stories in the application of pay-for-performance models, such as the significant improvement in three process measures related to dialysis adequacy and anemia management used in Medicare's End-Stage Renal Disease Quality Incentive Program,³³ an 8 percent decrease in Medicare all-cause 30-day hospital readmission rates, and a 17 percent decline in hospital acquired conditions.³⁴

Despite the successes (i.e., improved quality and lower health care costs) in the use of quality measures for reporting or performance, there are still problems. The majority of measures are process measures (i.e., whether an action was completed, such as administering a drug), which are arguably not always a predictor of an appropriate health outcome. For example, CMS had a measure for community-acquired pneumonia that assessed the appropriate administration of antibiotics within a certain time frame (within six hours).³⁵ In this case, making antibiotics a quality measure led to inappropriate use (i.e., overuse) of antibiotics, because providers administered antibiotics to patients without community-acquired pneumonia.³⁶ This measure was ultimately removed from the reporting program.³⁷ There is progress in use of more outcome-oriented measures but this progress needs to be accelerated.

Providers are experiencing increased frustration because of the requirement to report on measures for multiple programs and payers. There is concern that the proliferation of measures is resulting in measurement fatigue.³⁸ Indeed, an analysis of 48 state and regional measure sets (across 25 states and three regional collaboratives) found that there is little alignment across measure sets and that most programs modify a portion of their measures, which leads to an even greater lack of alignment. Specifically, the analysis found that across the 48 measure sets, an incredible 1,367 measures were in use, while only 20 percent of all measures were used by more than one program.³⁹ Similarly another study of 29 private health plans found that of the 550 distinct measures identified, there was little consistency with the public-program measures.⁴⁰ The volume of measures is so great that organizations must devote a large number of resources to gathering them. Moreover, as noted earlier, many metrics are not associated with the desired patient outcome.

CMS has more than 25 quality-reporting and -performance programs as well as initiatives that focus on a variety of health care settings, including hospitals, physicians, post-acute care, and others. The majority of these programs use higher reimbursement as incentive to the health care provider to report certain quality measures. For example, under CMS's Hospital Inpatient Quality Reporting (Hospital IQR) program, CMS is authorized to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. Those hospitals that don't successfully report receive a reduction, in the annual market basket, of two percentage points. CMS also publishes the data received by the hospitals, physicians, and other health care settings such as skilled nursing homes, so that the information is available to consumers on the relevant websites (e.g., Hospital Compare, Nursing Home Compare).

Before an ACO can share in any savings created, it must demonstrate that it has met the 33 nationally recognized quality measures for that year.^{41,42} For those eligible hospitals, providers and critical access hospitals participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, nine specific clinical quality measures out of a possible 64 must be reported in order to receive incentive payments.⁴³ Medicare Advantage's star rating program has 44 unique measures.⁴⁴

The ACA added multiple quality provisions designed to improve the health care delivered to Medicare and Medicaid patients. One such provision is a penalty-based quality improvement, which prohibits federal payments to states for Medicaid services related to acquisition of certain hospital-acquired infections, while another provision reduces Medicare payments for certain hospital-acquired infections and hospital readmissions. In addition, the ACA requires qualified health plan (QHP) issuers offering coverage through a Health Insurance Marketplace (i.e., exchange) to submit third-party-validated, quality-rating-system, clinical-measure data and QHP Enrollee Survey response data to CMS as a condition of certification.⁴⁵ More measurements are required for pediatric programs, and states have their own quality measures for private plans as well as for Medicaid programs. For example, there are more than 30 states that require the use of HEDIS and CAHPS quality measures for Medicaid managed-care plans.⁴⁶

Current Consolidation and Alignment Efforts

The CMS metrics described above are all well-intentioned quality-measurement activities, some of which are producing results. However, the proliferation of programs and reporting requirements has resulted in a lack of measures integration and wasteful redundancy. According to the 2015 National Impact Assessment of the CMS Quality Measures Report, mandated by Section 3014(b) of the ACA, fewer than half of the quality measures studied in that report aligned with other state and federal programs.⁴⁷ The report encompasses 25 CMS programs and nearly 700 quality measures from 2006 to 2013.⁴⁸ Although CMS has aligned many of its major quality programs, the need for alignment with the private sector and state programs is still needed. The need for alignment and downsizing has been an ongoing concern for years. Although there has yet to be a consensus on how to achieve a core set of measures, there have been efforts made by several groups that show promise toward a solution. The most recent and significant alignment efforts include:

The National Quality Strategy (NQS) was published in March 2011 and is led by the AHRQ on behalf of HHS. Mandated by the ACA, the NQS was developed through a transparent and collaborative process with input from more than 300 groups, organizations, and individuals, representing all health care industry sectors and the general public. The NQS provides a focus for addressing the profusion of clinical quality measures currently used in national programs. The goal of the NQS is to get to measures that matter and minimize provider burden.⁴⁹ HHS releases annual progress reports to Congress on the NQS.

The HHS Measurement Policy Council, convened in 2012 as a sub-group of the NQS Group, works on aligning measures across HHS. The Policy Council is composed of senior-level representatives from various federal agencies (i.e., AHRQ, CMS, the Centers for Disease Control, the National Coordinator for Health Information Technology, the Health Resources and Service Administration, the Indian Health Service, the National Library of Medicine, the Office of the Assistant Secretary for Health, the Substance Abuse and Mental Health Services Administration, the Assistant Secretary of Planning and Evaluation, and ACL

Laboratories) and operating divisions across HHS. This group also addresses new measure development and implementation, and measurement policy. To date, the Council has reviewed nine topics: hypertension control, hospital-acquired conditions/patient safety, HCAHPs, smoking cessation, depression screening and care coordination, HIV/AIDS, perinatal, and obesity/BMI. The Council has reached consensus to date on core measures for hypertension, smoking cessation, and depression and is working on other areas of alignment.⁵⁰

America's Health Insurance Plans (AHIP)/CMS/NQF are collaborating to align measures across public and private programs in hopes of creating consistency in the quality measures being used in government programs and by private insurers. This collaboration, led by AHIP, involves input from both public and private payers, including physician specialty organizations, and at some point also employers and consumers. The goal is to create core measure sets that offer consumers useful information for health care decision-making and reduce the burden on providers of reporting quality measures.⁵¹

The Institute of Medicine's Committee on Core Metrics for Better Health at Lower Cost is an ad hoc committee exploring measurement of individual and population health outcomes and costs, identifying weaknesses and gaps in health care systems, and considering approaches and priorities for developing the measures necessary for a continuously learning and improving health system. In its report (expected late April 2015), the Committee is to propose a basic, minimum slate of core metrics for use with respect to people's engagement and experience in health care, quality, cost, and health. In addition, the Committee will indicate how these core indices should relate to, inform, and enhance the development, use, and reporting on a more detailed set of measures tailored to specific conditions and circumstances; and identify needs, opportunities, and priorities for creating and maintaining a metrics capacity necessary for the optimal use of the core metrics.⁵²

U.S. Department of Health and Human Services: Better, Smarter, Healthier Initiative. In January 2015, HHS announced a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as ACOs or bundled-payment arrangements by the end of 2016 and 50 percent by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. To make these goals scalable beyond Medicare, HHS created a Health Care Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs.⁵³

The IMPACT Act (P.L. 113-185): The president signed the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), bipartisan legislation that sets forth new and streamlined quality measures across nursing homes, home health agencies, and other post-acute care providers participating in Medicare. The IMPACT Act also requires

more frequent surveys of hospice providers—a measure the hospice community and the National Hospice and Palliative Care Organization has championed for more than a decade.

The Measure Applications Partnership (MAP) is a public-private partnership convened by the NQF for providing input to HHS (for its pre-rulemaking process) on selecting performance measures for public reporting, performance-based payment, and other programs. The goal of this partnership is essentially to streamline performance metrics—examining which metrics are relevant for various federal applications, providing input to HHS, and encouraging alignment of public- and private-sector measurement initiatives.⁵⁴ MAP is set up to encourage alignment across federal programs and implicitly encourages public-private alignment, but federal task orders do not provide the resources for such work.

Where We Are Today

These alignment initiatives and programs are making contributions toward moving to a value-based health care system, and there has been some measurable success. For example, from 2010 to 2013, hospital-acquired conditions have fallen by 17 percent.⁵⁵ This progress is due in part to Medicare payment incentives described above, as well as the Partnership for Patients initiative launched by the CMS Center for Medicare and Medicaid Innovation.⁵⁶ However, we are still far from reaching the goal of simplifying providers' experience while maximizing benefits to beneficiaries and payers.

According to recent reports, 33 different CMS programs used over 1,000 measures in the second quarter of 2014.⁵⁷ Roughly half of those measures were unique measures.⁵⁸ As noted above, CMS requires health plans to report a variety of performance measures to receive rewards, such as enhanced reimbursement (or a decrease in payment if measures are not satisfactorily reported).⁵⁹ States also require measures to be used for Medicaid managed-care programs or by plans through regulation from the states' health insurance department.

As previously noted, stakeholders in the quality debate (plans, providers, employers, and consumers) agree that current quality measures are not achieving their potential in improving quality of care. They embrace the vision of a core, consolidated set of outcomes-based quality measures that can be used across payers. However, achieving the vision has proved extremely difficult, despite the best of intentions, because individual stakeholders have generally failed to achieve consensus around which measures should be prioritized and how they should be used.

While these individual stakeholders' concerns about particular measures are often valid, the objections have undermined the stakeholders' broader consensus about what is needed to achieve their goal of a much more workable and actionable approach. In part, the failure to reach consensus is a disagreement on the purpose of the measures (i.e., improved patient safety, or other care outcomes; reimbursement; or making information available to businesses, plans, and consumers) and whether the measurement actually achieves its purpose (i.e., prevention of hospital-acquired conditions or improved patient satisfaction). This fundamental disagreement has led to frustration and failure to reach agreement on core measures.

Without question, there will never be a perfect set of measures in which there is universal consensus. However, today's health care delivery models are moving forward at an unprecedented rate, and failure to reach consensus will not slow these models although they could discourage provider involvement. They will continue to move forward with the current patchwork of measures, which are administratively burdensome to providers, have

significant information gaps, and provide little meaningful information to consumers or businesses that are making decisions on the quality of plans and providers.

Clearly, progress in the prioritization and consolidation process with the goal of improving care and the care experience needs to be accelerated, even if those measures are not perfect today. Failure to achieve progress in this area may undermine confidence in the new systems of care that emphasize performance or reporting of measures as a way to achieve value-based delivery of health care. We should not let the goal of having the perfect set of core measures impede progress in the short-term. As such, efforts to transition from the status quo to a better system should not be impeded because there are not core measures for every setting or specialty. Such an approach could include versions 1.0, 2.0, 3.0, and others, which should be agreed upon and implemented, with the recognition that the latest version can and should be improved over time. This process should be done, however, with the participation of and buy-in of the key stakeholders who deliver, receive, and pay for care. Given the imperative of producing a core set of measures, policymakers should implement version 1.0 of a core set of quality measures to use across all payers and providers, beginning with primary care measures that are already in progress and later, moving into specialty care. BPC's core set begins with physician measures—arguably because this is the sector that is most challenged, with the lack of alignment and the burden it places on small-to-midsize physician practices in particular.

BPC Recommendations

Although the measurement process is far from complete or mature, the point worth making is that quality can indeed be legitimately quantified, measured, tracked, and trended just like many other business variables and activities. A problem that must be recognized, however, is that different constituencies view quality management and performance measurement differently. For example, some payers may see the goal as patient safety, while for others, the goal may be improving quality or lowering costs. The following recommendations incentivize the use of a core set of quality measures to use across all payers and providers, beginning with primary care measures and later, moving into specialty care. Recognizing the difficulty of reaching consensus, BPC leaders believe that the current system is broken and that we will not recognize the potential of delivery system reform without a core set of quality measures across payers.

Although BPC's Health Project is focused on the development and use of core measures as described in this report, other BPC health program initiatives, specifically the Prevention and Health Innovation Initiatives, are also exploring issues related to quality.

BPC's Prevention Initiative has convened a Prevention Task Force to explore ways to better finance prevention and embed it in health care delivery system reform. In their forthcoming report, the task force will recommend that CMS integrate two to four population-health quality measures into the next generation of ACOs to drive system change that supports health by reducing the prevalence of risk factors and the incidence of disease.

BPC's Health Innovation Initiative has conducted considerable work associated with the use of information technology to support new models of care, building upon its initial work in this area, as outlined in the report, *Transforming Health Care: The Role of Health IT*. Getting to accurate, timely performance measurement requires—among other things—electronic access to data that resides in multiple, disparate systems; the use of data standards; accurate matching of patient data across multiple systems; and adjustments in work flow to assure that the appropriate data is collected at the right time and place. Considerable work is needed to align existing IT infrastructure within the U.S. health care system today with timely, accurate performance measurement. In the coming months, the Health Innovation Initiative will release a set of findings and policy recommendations to improve the alignment of IT investments with the needs of performance measurement.

Recommendation 1: Support ongoing private-sector efforts. Private-sector stakeholders, in coordination with CMS, should identify core measures for use across payers and delivery systems.

BPC supports ongoing private-sector efforts (AHIP and primary and specialty care medical societies working in conjunction with CMS and NQF) to agree on a core set of evidence-based quality measures and encourage private-sector leaders to continue these efforts. Over time, those working to agree on core measures will expand stakeholders to include consumers and their representatives, business groups, other providers and states. The importance of the integration, involvement, contributions, and support of these users cannot be overstated. All parties involved must understand and accept that any progress will certainly not reflect the final step in the process of securing extremely good quality measures. If done right, this process and the products it produces will evolve and improve over time. As measures are agreed upon, providers and payers should coordinate with health IT vendors to assure standardization and feasibility of provider reporting of each identified core measures.

Recommendation 2: Develop an easily understood quality rating system for consumers. Measures should be converted into a rating system that can be understood by consumers. This translation should be done by the same private stakeholder group in coordination with CMS and with strong involvement of consumer groups. For example, CMS could use a system similar to (a revised and improved) Medicare's star rating system.

Currently, the content and publication of health-quality information is available to consumers in a wide variety of displays. To name a few, there are performance measures on hospitals, nursing homes, hospices, and home health agencies that are publicly available on the HHS Web-based compare sites. There are quality ratings of quality health plans and providers that will be displayed starting in 2016 as part of the state and federal marketplaces. There is published comparative information on health plans, displayed as HEDIS measures. Regardless of the source, quality measures can be presented in a variety of ways and thus are hard to measure in a consistent manner. For example, the majority of measures show positive actions or outcomes, so the higher those measures score, the better; whereas for measures that focus on negative outcomes, such as mortality, a lower score is better.⁶⁰ For consumers, this lack of comparability can create confusion. Slightly different measures (lookalike measures) can also be reported that add burden to providers and confuse consumers.

To help facilitate the implementation of these measures and to replicate approaches that are gaining more acceptance, private stakeholders (especially those organizations with experience in providing understandable information to consumers), in cooperation with CMS, should utilize something along the lines of the star rating system, which is now being used by CMS and Medicare beneficiaries to assess Medicare Advantage health plans. The

measures focus on an array of clinical quality, customer satisfaction, and other beneficiary experience areas. Critics, such as the Government Accountability Office, question whether the program is rewarding mediocre care.⁶¹ Other critics argue that the star rating standards are difficult to measure. However, in January of this year, CMS strengthened the rating program to give families and beneficiaries more meaningful information. Consideration should be given to the applicability of this steadily improving quality-measuring tool in the private sector.

Recommendation 3: Emphasize role of a standards-setting organization. The identification of core measures will require a national standards-setting organization to continually endorse measures and recommend selection; the organization will also identify and prioritize key measure gaps to fill. CMS and Congress should continue to support this effort.

The development of a set of core measures will require a continuation of ongoing efforts to identify and adopt evidence-based and consensus-based measures. It is important that core measures be meaningful and that a process to address gaps in measures continues. For example, MAP is a public-private partnership that was established by the ACA, and it represents an important innovation in the regulatory process. Convened by the NQF, the MAP's primary purpose is to provide input to HHS on selecting performance measures for public reporting, performance-based payment programs, and other purposes. It will be imperative to make sure that the "endorsed" measures are evidence-based, scientifically valid and reliable, and able to discriminate performance so as not to misclassify providers and pay incentives to the wrong measures.

As part of the alignment effort described above, NQF should develop pathways that allow clinically relevant quality and cost measures to be accelerated in the process toward an endorsement for intended use. For example, the measures could be used initially for quality-improvement purposes, and those that meet more rigorous standards could be used for payment. In addition to promoting safety and clinical improvement, quality metrics enable accountability for health care dollars flowing from public and private payers. NQF is in an excellent position to ensure the process for creating these pathways is balanced and includes input from relevant stakeholders, such as the federal government, employers, and consumers.

Recommendation 4: CMS must promulgate measures for physicians, QHPs, hospitals, post-acute care, and ultimately across all provider groups. CMS should promulgate core measures as part of the PQRS and other reporting initiatives, and it should apply them across reimbursement models. As measures are promulgated, providers should be relieved of other reporting requirements.

The Physician Quality Reporting System (PQRS), a program under CMS, is an example of penalties being applied if providers do not meet the measures. While participation in PQRS is currently voluntary, beginning this year, all providers eligible for incentive payments will be subject to penalties for failing to participate. The penalty begins with a 1.5 percent reduction for providers who fail to report on the minimum measure set and will increase to a 2 percent reduction in reimbursement in 2016 and 2017. Due to passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the payment implications associated with this program – and two others: the EHR Incentive Programs and the Value-Based Modifier (VBM) – will sunset at the end of 2017. The goal of the PQRS program is to incentivize the discussion of quality-oriented questions between patients and providers, and to promote awareness among providers of the opportunities for quality improvement present in daily care and process.⁶² In addition to sunsetting the payment implications, the recently-passed MACRA legislation consolidates PQRS, the EHR Incentive Programs, and Value-Based Modifier into a single system that reduces conflicts and streamlines the reporting process. MACRA also includes requirements for the HHS Secretary to develop, publish, and report to Congress on a quality measure development plan for provider participation in the new “Merit-Based Incentive Payment System” (MIPS) and qualifying APMs; it also extends funding for quality measure endorsement, input, and selection at \$30 million for each of fiscal years 2015 through 2017.

One of the objectives of developing a core measures set is to relieve providers of the responsibility of reporting on multiple measures for multiple purposes. As core measures are promulgated, providers should be relieved of other reporting requirements under Medicare and should be credited as having met Medicare requirements of PQRS, electronic clinical quality measures within the CMS Medicare and Medicaid EHR Incentive (or “Meaningful Use”) program, and other reporting requirements under Medicare. This approach should bring providers to the table to negotiate with the private stakeholder group and CMS on measures appropriate for their specialties. The Center for Consumer Information and Insurance Oversight will coordinate private insurance standards with the Departments of Labor and Treasury. Under current regulatory structure, HHS, Labor, and Treasury promulgate private insurance standards and such to assure that employers also utilize the same core metrics.

Recommendation 5: Incentivize Medicaid and non-QHP state-regulated plans.

States that implement core measures in Medicaid (including pediatric measures) should receive an increase in FMAP (1 percent) for the first two years of implementation for claims made by plans or providers reporting core measures to the states. States must use these measures in lieu of other duplicative measures to receive enhanced matching.

States should be a part of the development of core measures, and they could be incentivized through Medicaid to participate and use the measures. As previously noted, a 2013 study found little alignment across 48 regional and state measure sets. Of the national standard measures used in these regions’ and states’ measure sets, not one measure

appeared in every set. Further convoluting the problem, states and regions often modify the measures and utilize non-standardized measures.⁶³ Misalignment of measurement between federal and state programs can undermine value-based purchasing initiatives especially if providers are receiving mixed clinical messages. Varying measures can also impede the ability to measure and pay on the basis of comparative performance if measures are not comparable across programs. A public-private alignment across Medicaid and states must be facilitated in order to achieve the implementation of a core set of measures across all payers.

Conclusion

While it is clear that the quality movement has advanced considerably, the lack of standardized performance measures has made it difficult to make comparisons across institutions' practices. Much better systems and more timely access to clinical information are needed for managing measures and helping people make informed decisions about their care.

Meaningful core quality measures can offer a wide variety of benefits to health care providers and consumers. Providers are asked to report on a variety of quality measures mandated by different entities, including physician registries, Medicare and Medicaid as a condition of reimbursement, and private plans as a precondition to participation, just to name a few. Often, the roles and responsibilities of organizations such as health plans and accrediting bodies are ill-defined in the area of quality reporting, leading to confusion and inefficiencies. This lack of clarity can place an unnecessary administrative burden on health care providers, forcing them to use resources to report on redundant, conflicting, or irrelevant metrics. Moreover, these inefficiencies with the current disjointed reporting system do little to address the more critical goals of allowing providers to objectively assess their own performance and strive to improve the quality and safety of care. Repairing this current, dysfunctional system will require a cooperative effort among all quality stakeholders, a clear vision with defined priorities, and a willingness to work toward common goals, such as simplifying the provider's experience while maximizing benefits to the beneficiaries and payers.

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