**Accountable Care Quality Measures Subgroup**

**Conference call**

**August 20, 2013**

Attendees:

Subgroup Members:

Joe Kimura (co-chair)

Terry Cullen (co-chair)

Sam Van Norman

Eva Powell

Paul Tang

Ted von Glahn

ONC Staff:

Kelly Cronin

Amy Helwig

Kevin Larsen

Heidi Bossley

CMS Staff:

Michelle Warner

Lisa Lentz

John Pilotte

External presenter(s):

Janet Corrigan

Introductions and Overview of Charge

The co-chairs provided an overview of the charge to this subgroup and the goals of this first meeting.

This subgroup was asked to develop recommendations for the next generation of e-measure constructs that are patient-centered, longitudinal, cross settings of care where appropriate and address efficiency of care delivery. These measures should be feasible to develop and implement in the next 2-3 years. In order to represent the various models by which patients currently receive care, a use case of Accountable Care Organizations (ACOs) will be developed showing how the recommendations on the domains, concepts, and infrastructure can be applied.

An addition was made to the charge in the last week that asks this group to develop recommendations for how electronic clinical quality measure concepts and specific measures could be used in place of MU objective measures. The goal is to “deem” eligible providers (EPs) and eligible hospitals (EHs) as meaningful users through their ability to perform on quality outcomes. The HIT Policy Committee would like this work group to give recommendations on specific quality outcome measures that will demonstrate meaningful use of HIT.

There has been some previous discussion on a potential “deeming” option by the Meaningful Use Workgroup. For example, if you perform at a certain level on a set of outcome eQuality measures such as in top quartile of performance or demonstrating improvement to move closer to the top quartile, the entity could be “deemed” to satisfy the MU functional requirements.

For this additional charge, the subgroup of the Quality Measures Workgroup will look at the MU Stage 3 program overall and identify the e-quality measures that focus on outcomes and are HIT-sensitive (meaning that HIT must be heavily relied on in order to enable high performance). The Quality Measure Workgroup will look at those measures that currently exist that could be considered for this alternative option of “deeming” and the Accountable Care Quality Measures subgroup will look at those in the pipeline and identify where there are measure gaps.

The subgroup will also look at how group reporting could be enabled in Stage 3. Specifically addressing whether there should be a group reporting option? What would it look like? What constitutes a group? How should the program address portioning the reporting of an individual clinician who participates across multiple groups?

The recommendations of the second part of the charge will be presented to the Quality Measures and Meaningful Use Workgroups and the final recommendations will be discussed on four calls over the next two months to be presented at the October or November HIT Policy Committee meeting.

Presentation on Patient-centered Measures of Value by Janet Corrigan

Following the discussion of the charge, Janet Corrigan provided an overview of a potential framework on patient-centered measures of value that was developed by the Gretzky Group a few years ago. Janet Corrigan and Elliott Fischer established the Gretzky Group with goal of looking at what the measures would be in the future.

At that time, measures that were appropriate for use by ACOs were not widely developed and endorsed by the National Quality Forum. This group completed a deep dive on what a framework would look like for ACOS and defined outcomes and experience over expenditures as an equation to define value. Approximately two-thirds of the attendees were from existing or emerging ACOs and the remaining were national representatives from employers, consumers, measurement experts and others. They first identified the subdomains and then developed measures that would be appropriate under each domain and subdomain.

Several overarching principles were used when developing the framework:

1. It was important to have a balance between accountability and quality improvement (QI) measures. ACOs have the opportunity to have high-level system indicators to assess value but it was agreed that ACOs also needed to be able to roll down to the subdomain level for QI and hopefully produce real-time data for clinicians and patients at the point of care.
2. It was important to emphasize measures that are generated from patients (i.e., patient-reported data). For this reason, many of the subdomains include patient-reported data such as under functional health.
3. The group wanted measures that were publicly available and vetted.

When looking at the framework, the domains and subdomains under Outcomes includes measures that are broadly applicable across the population as well as disease/condition-specific measures that could be measured longitudinally (e.g., hip and knee replacements). While measures were identified under each domain and subdomain, the group recognized that other measures could be used in place of what is currently included.

For Patient Experience, CAHPS was identified as the leading measure for the domain with more granular measures included under the subdomains. The group had much discussion on what belonged in the domain versus the subdomain and some felt that it was important that the overall patient experience be reported at the individual clinician level as well.

For Expenditures, it seemed most appropriate to look at total cost and then breakdown by expenditures and utilization and adjust across the areas of the US.

One other point that generated discussion across the group was whether the framework paid adequate attention to safety measures. Arguments could be made that more focused measures could be included along with an overall measure on patient safety.

When looking at the measures included in the framework, it would require a good deal of thought of how to capture patient-reported data especially across settings and longitudinally with a diverse array of ways to capture this data to encourage use. It was also agreed that the measures should be integrated into the care process with real-time access to data to facilitate decision-making by the physician and patient. Evaluation of how useful these measures are should also be evaluated.

Questions were then asked by the subgroup members on the framework including:

* How are the three domains balanced and how would they be used to evaluate performance across the ACOs?
	+ The Gretzky group agreed that all three should be included and that there were inter-relationships across the three categories but no weighting was recommended. The group focused more on what was captured in each domain (e.g., expenditures should include indirect and direct costs).
* Which measures within this framework would be identified as HIT-sensitive?
	+ While HIT-sensitivity was not a focus for the group, there are several that could be identified as HIT-sensitive such as functional health and health risk.
* Could there potentially be some movement of the measures from a subdomain to a domain or vice versa?
	+ Yes, while there needs to be a balance on what is included for accountability to enable use by consumers, it was envisioned that some measures could be moved into the overall measures for a period of time if desired.
* Did the group envision an overall calculation of value based on the equation?
	+ It was the aspirational goal of the group to move in this direction; although, it was not seen as feasible in the short-term. The primary focus was to develop a parsimonious set of measures.
* Were any unintended consequences of using the equation identified based on the relationship of the three domains (e.g., if an ACO lowers costs, could poorer performance on outcomes and/or experience allow the performance to still appear acceptable)?
	+ Unintended consequences are not known at this time but it should be examined further. For example, expenditures could be reported in bands with the performance of the other two domains reported against them.
* How is the availability or lack of resources factored into this framework? Could allocation of public expenditures (overall health vs. healthcare costs) be included?
	+ This question was not discussed when this framework was developed a few years ago but since then there has been some work to look at the total cost of health and not just health care costs. The first step would be to look at health care plus social supports and then we can begin to look at additional supports that are available to individuals. If we could get to total cost of health and link to outcomes and experience, there is the potential to reallocate some health care costs to social determinants rather than just decrease dollars spent on the health care side. The challenge is that the impact on these investments in social determinants would not be seen for potentially 10 to 15 years.

Subgroup Discussion of Potential Framework

CMS staff (Arjun Venkatesh) mapped the Patient-centered Measures of Value framework to the National Quality Strategy (NQS). While there is a commitment by HHS agencies to follow the NQS and staff will ensure that the final product relates to the NQS, the subgroup may determine that it needs to be reorganized, have additional subdomains included, or there may be other ways to represent the information. It also shows where there may be areas that are not robustly represented within the NQS.

Currently, this mapping only represents the domains and subdomains. The subgroup asked that the measures or examples of the measures used in the MU and ACO Pioneer programs be included under each domain or subdomain – by outcome and process. This will help the subgroup identify where there are measures including those that are eMeasure ready as well as those that address population or community-relevant measures such as available resources in the community.

Presentation on Medicare Shared Savings Program (MSSP) by John Pilotte

Those ACOs who participate in the MSSP or Pioneer programs just completed a round of quality reporting for the 2012 calendar year. Currently, there are 220 ACOs participating in MSSP covering 3.2 million assigned beneficiaries in 47 states plus the District of Columbia and Puerto Rico. The type of ACOs varies with over half being provider/physician networks.

The MSSP has aligned quality measurement with other programs such as the Physician Quality Reporting System (PQRS) and have put forward a framework of measures across four domains:

1. Patient/caregiver experience (i.e., CGCAHPS)
2. Care coordination/patient safety (e.g., readmissions, medication reconciliation, falls screening)
3. Preventive health (e.g., vaccines, screening)
4. At-risk population (e.g., high cost and prevalence chronic conditions in Medicare population, two all or none composites on diabetes and coronary artery disease)

To the extent possible, the data for the quality measures is collected using existing programs and interfaces and the ACOs just received the first feedback reports on the measures using GPRO and claims and the CAHPS responses will be received later this fall.

An overview of what was finalized in the MSSP and what is proposed through the Physician Fee Schedule rule was provided where there is a move to pay-for-performance and a quality scoring approach, which allows ACOs to earn points for a range of performance on a measure and incentivizes improved or high level performance.

Questions were then asked by the subgroup members on the MSSP including:

* What feedback on the relevance and burden of reporting the measures has CMS received from the ACOs?
	+ CMS has attempted to minimize burden through the use of existing data sources (i.e., claims, GPRO). All ACOs participating in the quality reporting for MSSP were able to submit the data but there was a wide landscape of experience and ability across the ACOs. It was agreed that collecting information on the level of effort required to collect and submit the data should be explored.

Presentation on the Pioneer ACO Experience Performance Measurement by Joe Kimura

One of the primary challenges that the ACOs faced when implementing the measures for the Pioneer program was even with the past experience with collecting and reporting measures there were differences in the measure details and specifications across programs and with the original NQF-endorsed measures. From the ACOs perspectives, the measure concepts were appropriate but were unsure of the fairness of the applying the measures to high stakes use when there were differences in operational implementation resulting in variation of results.

Sam Van Norman who also participated in the Pioneer program agreed with the concerns that the measures were no consistently applied across the ACOs and programs, which is critical.

Next steps

The subgroup will reconvene via conference call on August 26 and will work to finalize the framework, hear a presentation from CMS on current and future measure development work, and begin to discuss the measure concepts needed to move forward for ACOs and “deeming”.

ONC staff will look at the mapping of the two frameworks and provide either examples of the measures or the full list of the MU and ACO Pioneer measures under each domain and subdomain. The framework will also be examined to see how social determinants or other population-relevant factors could be seen as HIT-sensitive and readiness for the MU program.