# American Association on Health & Disability

110 N. Washington Street Suite 328-J Rockville, MD 20850

**T.** 301-545-6140 **F.** 301-545-6144 www.aahd.us


**AAHD -** Dedicated to better health for people with disabilities through health promotion and wellness

LAKESHORE

**Core Quality Measures Collaborative**
**March Draft Report for Public Comment**
**"Approaches to Future Core Set Prioritization"**

[Submitted electronically through the National Quality Forum website]

March 15, 2019

Dear Project Managers, Analysts, and Committee Advisors

**We are writing to express our disappointment that nowhere in the draft report are the following words and phrases used:**
**"Disability,"**
**"Long-Term Services and Supports -LTSS"**
**"Home and Community-Based Services – HCBS"**

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and

Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

**Importance of Medicaid Home-and-Community-Based Services and Supports (HCBS)**

HCBS has been defined by the National Quality Forum as "an array of services and supports delivered in the home or other integrated community setting that promote the independence, health and well-being, self-determination, and community inclusion of a person of any age who has significant long-term physical, cognitive, sensory, and/or behavioral health needs." [National Quality Forum, "Quality in Home-and-Community-Based Services To Support Community Living," final report, September 2016, page 9.]

Medicaid spending on HCBS users remains disproportionally high relative to their share of enrollment. In 2013, 4% of Medicaid enrollees who used HCBS accounted for 23.9% of Medicaid fee-for-service spending ($97.8 billion of $409.3 billion). [MACPAC, "Medicaid Home-and-Community-Based Services: Characteristics and Spending on High-Cost Users," June 2018, page 1] In 2014, HCBS accounted for the majority of Medicaid LTSS expenditures ($80.6 billion of the $152 billion spent by federal and state governments). National Quality Forum, "Quality in Home-and-Community-Based Services To Support Community Living," final report, September 2016, page 7.]

The stated purpose of the future core measures document is: "Aims to identify the most meaningful health care performance measures." We write to encourage that **HCBS Quality Measures Currently Used by State Medicaid and Disability Programs be added to the core measure set.**

**HCBS Quality Measures Are Currently Used by State Medicaid and Disability Programs**

The draft report identifies three possible options for the future:

1. Continue prioritizing by condition or specialty." Disparities, burdens of illness, quality of life, behavioral health, substance abuse, and neurology are mentioned. (pages 7-8)
2. Prioritize Cross-Cutting Areas. Care Coordination, transitions to care, access to care, appropriate use, patient-experience, and population health are mentioned. (page 9). **[We strongly support the inclusion and use of patient/beneficiary/participant/enrollee experience measures in all options.]**
3. Prioritize expanding the current core sets to other levels and settings (page 10)

The recommendation to include existing quality measures, used in multiple states, targeting home-and-community-based services, could be achieved under all three of these options.

We request that the project consider adding any of the following currently used by state Medicaid and Disability programs, home-and-community-based services and supports quality measures, each of which includes documented beneficiary/participant/enrollee experience:

1. National Quality Forum, MAP (Measure Application Partnership) endorsed and recommended for inclusion in the Medicaid core measure set – CAHPS (Consumer Assessment of Healthcare Providers and Systems) trade-marked, CMS-AHRQ developed, CAHPS HCBS Experience Survey;

2. National Core Indicators/for persons with intellectual and other developmental disabilities, NASDDDS & HSRI;

3. National Core Indicators/aging and physical disability; NASUAD & HSRI; and

4. Personal Outcome Measures; CQL

Thank you for considering our views, experiences, and frustrations.

Sincerely,

**E. Clarke Ross, D.P.A.**
Public Policy Director
American Association on Health and Disability
clarkeross10@comcast.net
Cell: 301-821-5410

Member, National Quality Forum (NQF) workgroup on Medicaid adult measures (December 2017-present) and Medicaid-CHIP Scorecard Committee (October 2018-present). Member, National Quality Forum (NQF) workgroup on persons dually eligible for Medicare and Medicaid (July 2012-July 2017) and NQF population health task force (2013-2014) http://www.qualityforum.org/) and NQF representative of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports ( http://www.c-c-d.org/). 2017 member, NQF MAP workgroup on Medicaid adult measures. 2016-2017 NQF duals workgroup liaison to the NQF clinician workgroup. 2015-2016 and 2014-2015 NQF duals workgroup liaison to the NQF PAC/LTC workgroup. Member, ONC (Office of the National Coordinator for Health Information Technology) Health IT Policy Committee, Consumer Workgroup, March 2013-November 2015; Consumer Task Force, November 2015-April 2016. (http://www.healthit.gov/policy-researchers-implementers/federal-advisory-committees-facas/consumer-empowerment-workgroup). Member, SAMHSA Wellness Campaign National Steering Committee – January 2011-September 2014. (http://promoteacceptance.samhsa.gov/10by10/).

**Roberta S. Carlin, MS, JD**
Executive Director
American Association on Health and Disability
110 N. Washington Street, Suite 328J
Rockville, MD 20850
301-545-6140 ext. 206

301 545-6144 (fax)
rcarlin@aahd.us

**Amy Rauworth**
Director of Policy & Public Affairs
Lakeshore Foundation (www.lakeshore.org)
4000 Ridgeway Drive
Birmingham, Alabama 35209
205.313.7487
amyr@lakeshore.org

# Approaches to Future Core Set Prioritization

## Background

Transforming healthcare payment from volume to value requires quality, patient experience, and efficiency metrics to assess the success of the models and their participants. The increased reliance on performance measures as part of these models led to a proliferation in the number of measures and a commensurate increase in burden on providers collecting the data, confusion among consumers and purchasers seeing conflicting measure results, and operational difficulties among public and private health insurance providers.

Promoting alignment by identifying core measure sets constitutes one strategy to reduce the burden of measurement. The CQMC defines a core measure set as a parsimonious group of scientifically sound measures that efficiently promote a patient-centered assessment of performance specific to a particular topic area. Value-based purchasing and alternative payment models should prioritize the inclusion of measures in the core sets. The CQMC seeks to continue its work through ongoing maintenance of the existing core measure sets to reflect the changing measurement landscape, including, but not limited to, changes in evidence-based clinical practice guidelines, data sources, or risk adjustment. It further seeks to expand into new topic areas not yet addressed. In addition, the CQMC seeks to identify gaps in measurement and challenges in implementation in order to advance adoption of the core sets.

## Prioritization of Topics for New Core Sets

The CQMC initially developed eight core sets in areas identified as high priority by its members. However, the group recognizes that additional conditions and clinical areas or cross-cutting topics could benefit from the creation of a core set of measures. The CQMC aims to identify the most meaningful healthcare performance measures and prioritize them for implementation. However, multiple stakeholders use performance measures, and those stakeholders may have varying perspectives on the goals and priorities for measurement. The potential for differing stakeholder views highlights the need for a thoughtful and consensus-based approach to the selection of topics for additional core sets.

To facilitate the CQMC's decision about how to prioritize areas for additional core sets, NQF has developed potential approaches to prioritizing new topics. To guide this effort, NQF staff conducted an environmental scan of approaches used by other initiatives seeking to develop core sets, as well as identified conditions that have high incidence or prevalence or high healthcare spending and would benefit from increased measure alignment to drive coordinated improvement in key areas while minimizing provider burden.

## Environmental Scan Findings

NQF searched for efforts by other groups that are developing or have developed core sets of measures or that have identified principles for a core set. NQF initially identified 18 initiatives. These initiatives

were included if they had publicly available information describing why their core set topics were selected and/or how they were prioritized. Efforts that established principles for measure selection, but did not create specific sets of measures were excluded. Twelve national and state efforts fit the inclusion criteria for this scan. NQF assessed the initiatives' rationales for selecting certain focus areas for their core sets and categorized each initiative by the approach used.

Some themes arose across the efforts. The majority of efforts created core sets in response to a specific need or requirement such as legislation or as an awardee of the State Innovation Models (SIM) Initiative.[1] Some efforts focused on creating one core set of measures to address a specific purpose (e.g., for use in Accountable Care Organizations) while others have created multiple sets addressing different topics (e.g., a set of measures to include in hospital contracts and a different set to include in clinician contracts).

The scan revealed five general approaches to identifying topics for core sets:

1. Stakeholder priorities
2. Cross-cutting topics (e.g., apply to multiple conditions, settings, or models)
3. Payment model specific
4. Setting specific
5. Specialty specific (current CQMC approach)

A summary of each effort identified and its prioritization approach is included below.

## *Efforts Focused on Stakeholder Priorities*

**National Academy of Medicine (NAM) Vital Signs[2]**

The Vital Signs initiative focused on identifying measures for the health influences, characteristics, and interventions that would have the most influence on four domains: healthy people, quality of care, costs of care, and engagement in health and healthcare. The NAM committee considered the potential core measurement needs, priorities, and challenges for key stakeholder groups, including patients, families, and the public; clinicians; healthcare organizations; payers and employers; public health agencies at multiple levels; regulatory authorities; grant-making organizations; and media. One set of measures was chosen and intended to apply across all conditions.

NAM was specifically charged to identify measures that could improve population health outcomes and healthcare costs, and they prioritized measures that could achieve transformation across the system to promote these goals. Through its research, the committee identified four interrelated domains that could address these goals: healthy people, care quality, care costs, and engagement in health and healthcare. Measures were prioritized for the set if they advanced these specific goals. NAM's report on the development of the core set noted that the committee considered developing a set that included process measures but decided to focus on outcomes. Similarly, the report noted that NAM also considered focusing on individual disease areas but chose not to pursue that approach, as other measures could have a greater impact, address progress at multiple levels of the system, and maintain parsimony. This approach allowed NAM to develop a parsimonious and focused set. However, working backwards from specific goals meant that numerous areas did not have measures currently available. This approach could limit the CQMC's ability to promote alignment of measures currently in use.

**New Jersey State Innovation Model[3]**

In 2015, New Jersey was awarded a State Innovation Model (SIM) Design Grant from the Center for

Medicare and Medicaid Innovation (CMMI). The SIM had as its goal to design a payment and service delivery model to reduce Medicare, Medicaid, and CHIP program expenditures while preserving or enhancing quality of care. The grant aimed to build on state initiatives already underway and the NJ SIM was designed to advance behavioral and physical health integration strategies; address Medicaid cost/value, especially for high-cost, complex patients; and improve birth outcomes through smoking cessation efforts, particularly among pregnant women.

Quality measure alignment was chosen as a core domain of the project activities. The work focused on aligning quality metrics across payers and the delivery system to improve quality and reduce redundancy and avoidable costs. The committee overseeing the alignment review prioritized the following considerations for measure review: (1) the relative importance for value-based system improvement; (2) the degree to which reporting requirements vary across payers; (3) metrics where reporting burden might outweigh their importance; and (4) where other opportunities to streamline measurement and reporting may exist. This initiative created a core set of measures through a multistep process. The first step was to identify the various state and federal quality and efficiency improvement initiatives and then create an inventory of metrics required under each initiative. The next step was to de-duplicate the list of metrics and identify those most commonly used. Measures on that list were then reviewed for meaningfulness and usability. Due to time constraints, this effort focused on outpatient measures rather than hospital inpatient measures.

This approach reviewed currently implemented measures for the outpatient setting to advance the specific goals of the NJ SIM. This approach allowed for the creation of a parsimonious set of measures currently in use. However, this approach focuses on a specific time and may not allow for the addition or removal of core measures as needed. Similar to the CQMC, the initiative focused on outpatient measures, but using this approach may leave gaps in alignment for inpatient settings.

**Rhode Island Aligned Measure Sets[4]**

Rhode Island created a common set of quality measures to promote alignment across payers and reduce provider reporting burden. Rhode Island's State Innovation Model Grant supported the initial efforts. The goal of the aligned measure sets was to support a state goal of tying 80 percent of healthcare payments to value by addressing consistency of measures and provider burden. The vision for the core set was to create a menu of measures from which payers could select and a core set of measures to be included in all contracts. Areas for the core sets were selected based on payer interest. The first aligned measure sets focused on primary care, ACO, and hospital contracts. In 2016, additional measure sets were developed for behavioral health and maternity.

The process began with a review of existing measures used in value-based contracts between payers and providers in Rhode Island. A cross-walk was created between these measures and the measures in the CMS Medicare Shared Savings Program and Five-Star Quality Rating System, as well as the population health goals outlined in the SIM. Of note, the Workgroup charged with developing the sets was silent on whether measures shall be used for payment only, versus payment and/or reporting. Additionally, the workgroup noted that specific targets and incentives associated with the measures would be left up to negotiation between the health plans and providers.

The approach was designed to capitalize on payer interest and to meet the goals of the SIM. This process resulted in a clear vision for the sets and alignment of measures currently in use. Additionally, this approach allowed for prioritization of areas where there was misalignment in value-based purchasing (VBP) contracts and supported the state's desire to transition to greater use of VBP. This

approach, however, may limit alignment of specialty-specific measures.

**Washington State Common Measure Set for Health Care Quality and Cost[5]**

Washington law mandated the creation of a statewide common measure set. The law created a Performance Measures Coordinating Committee charged with recommending standard statewide measures of health performance to inform public and private healthcare purchasers. Additionally, the Healthier Washington Initiative set a goal for 80 percent of all health plans and health care delivery systems in Washington State to use the Statewide Common Core Set of Measures by 2018. The core set was intended to evolve over time as measurement science advances, and a list of priority measure development areas was identified as part of its creation. This list focuses the research and recommendation of additional measures for the core set. Additionally, new topics for measure review and consideration can be identified based on state purchaser priorities.

The common measure set aims to promote voluntary measure alignment among state and private payers and to address specific state goals and needs. Measures in the set focus on access to primary care, acute care, prevention, and chronic care.

This approach focuses on addressing the priorities of public and private healthcare purchasers and aims to ensure purchasers are invested in promoting adoption of the core set. This approach also resulted in the identification of gap areas where measures are not available. This approach, again, may limit the availability of specialty-specific measures.

### *Efforts Focused on Cross-Cutting Priorities*

**Measure Applications Partnership (MAP)[6]**

MAP is a multistakeholder body convened by the National Quality Forum. MAP provides guidance on measures under consideration by the Centers for Medicare and Medicaid Services for use in its public reporting and VBP programs. To inform its measure selection work, MAP has developed sets of core measures. MAP's approach to prioritizing areas for the development of core sets was to focus the National Quality Strategy goals or on specific populations: dual eligible beneficiaries and rural health.

MAP adopted the approach of aligning with the aims of the National Quality Strategy or addressing the needs of specific populations to ensure measures are targeting important concept areas. This strategy aimed to promote broad improvement across the health system. MAP selected this approach to allow users of the core sets to achieve a twofold goal of tracking progress towards key improvement priorities and promoting alignment around best available measures. However, this approach could have key limitations. Measures may not work at multiple levels of analysis as currently specified, leading to the need for multiple measures addressing a similar topic. Moreover, this approach also led to the identification of numerous areas without available measures. This approach may allow the CQMC to include measures that span many conditions but, again, could be limited by the availability of appropriate measures.

### *Efforts Focused on Specific Payment Models*

**Oregon Medicaid Metrics and Scoring Committee Criteria for Selecting Incentive Measures[7]**

The Oregon Health Authority (OHA) measures quality of care and access to care for individuals enrolled in coordinated care organizations (CCOs) and the Oregon Health Plan population as a whole. A CCO is a network of healthcare providers in a community who serve people who receive healthcare coverage under the Oregon Health Plan (Medicaid).

The measure set has as its goal determining which CCOs are improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve. State law created the Metrics and Scoring Committee to recommend measures to assess CCOs. The set addresses specific domains of CCO quality including service areas for which CCOs are responsible and domains prioritized for transformation, specifically, care coordination, patient experience, access, equity, efficiency and cost control, and community orientation. Measures were drawn from existing sets and are reviewed periodically based on CCO performance data, improvement over baseline, and distribution of the quality pool to determine if the selected measures are improving quality and access for the Oregon Health Plan population.

This approach allows for the creation of a measure set to support a specific model and advance quality goals for the population included in that model. However, the core set may have limited applicability outside of that model and population, limiting the impact of alignment activities.

**Maine State Innovation Model[8]**

In 2013, Maine was awarded a three-year State Innovation Model (SIM) Grant from CMMI. Among other goals aimed at achieving the Triple Aim, the SIM aimed to improve health in at least four categories of disease prevalence, including diabetes, mental health, obesity, and tobacco use. As part of the SIM, the Maine Health Management Coalition led a multistakeholder effort to develop a core measure set. A common set of core measures was created with the objectives of assessing ACO performance, aligning commercial and public payer performance measures, and reducing provider reporting burden. Performance on nine core measures broken out by MaineCare, Commercial, and Medicaid is displayed through a dashboard, allowing for the exploration of progress over time and in relation to 2016 targets.

The approach allows for the creation of a set to support specific goals and the use of a specific model. The potential drawback could be limited applicability in other models.

**Massachusetts Executive Office of Health and Human Services (EOHHS) Quality Alignment Taskforce[9]**

In 2017, the Massachusetts EOHHS convened a Quality Alignment Taskforce to create an aligned measure set for use in global budget-based risk contracts, Medicaid, and commercial ACOs. The measure set seeks to reduce burden and focus improvement efforts on state priorities. The taskforce was charged with recommending an aligned measure set for voluntary adoption by private and public payers and by providers in global budget-based risk contracts. The taskforce excluded ACO contracts for Medicare populations from its scope and did not consider measures for use in public reporting or in tiering of provider networks. The taskforce identified two goals for its work: (1) gain consensus on an aligned quality measure set for payers and providers to implement in global budget-based risk contracts and (2) to identify strategic priority areas for measure development where measure gaps exist.

The taskforce chose several ways to prioritize measures for the core set. First, it chose to include measures for both adult (nonelderly) and pediatric populations. Next, it identified 16 performance measure domains to represent important focus areas for the core set. Finally, the group chose to defer consideration and adoption of measures focused on inpatient care for future work. The taskforce used current measure sets as potential sources for its core set.

This approach allowed for the creation of a set that applies to a specific payment model and populations of interest. However, the focus on younger populations and measures for ACO models could limit the impact of alignment activities.

**Vermont All-Payer Model ACO[10]**

The goal of the Vermont All-Payer Model was to speed the transition from fee-for-service to risk-based payment models. The All-Payer Model enables the three main payers of healthcare in Vermont (Medicaid, Medicare, and commercial insurance) to pay an accountable care organization (ACO) differently than through fee-for-service reimbursement. This model is facilitated by state law and an agreement between the state and the Centers for Medicare and Medicaid Services (CMS). The model was facilitated through a partnership between the state's largest payers Medicare, Medicaid, and Blue Cross and Blue Shield of Vermont and with interest from a large established ACO.

To support this model, Vermont developed a set of core measures. To create this core set, Vermont prioritized three population health goals and built a quality framework around those goals: increase access to primary care; reduce deaths due to suicide and drug overdose; and reduce the prevalence and morbidity of certain chronic diseases. Overall, the quality framework consists of 22 measures across all payers and uses existing measures in order to minimize additional administrative burden.

This approach focused on developing a set to support payer and provider interest in payment reform and resulted in a parsimonious set advancing specific goals. However, this approach, built on Vermont's unique reform history, may not replicate nationally.

## *Efforts Focused on Specific Settings*

**Health Care Quality Measures-Minnesota Department of Health[11]**

Minnesota's 2008 health reform initiative required the establishment of a standardized set of quality measures. This standardized quality measure set is called the Minnesota Statewide Quality Reporting and Measurement System. Physician clinics and hospitals have been reporting quality measures under the statewide system since 2010. Health plans may use the standardized measures and may not require providers to undertake reporting on measures outside of the system. Measures are categorized based on setting: physician clinic or hospital. The hospital set is further separated into measures for prospective payment system hospital, critical access hospital inpatient, critical access hospital outpatient, and prospective payment system and critical access hospitals.

This approach covers a broad range of providers, and legislation limiting the use of measures outside this system supports measure alignment. This approach is built upon state reforms and local partnerships, and replicating it elsewhere could prove challenging.

## *Efforts Focused on Specific Specialties*

**Kentucky Core Healthcare Measures Set (KCHMS)[12]**

The Kentucky Performance Measures Alignment Committee (PMAC) developed the Kentucky Core Healthcare Measures Set. The PMAC is a public-private partnership between Kentucky Department for Medicaid Services (KDMS) and the Kentuckiana Health Collaborative (KHC). The Kentucky Core Measure Set focused specifically on primary care and pediatric care measures. The goals of the core set are to identify priority quality measures that improve the quality and value of care, reduce provider burden, and align Kentucky's healthcare organizations to focus on key indicators. The set includes 32 measures grouped in areas of prevention, pediatrics, chronic and acute care management, behavioral health, and cost/utilization.

Focusing on primary care allowed for the development of a parsimonious set that could advance specific goals. However, other specialties and settings may not benefit from the alignment effort, and including these other providers could amplify improvement efforts.

**New York State Innovation Model**[13]

New York's State Innovation Model (SIM) focused on transforming primary care payment and delivery models. New York focused on using an advanced primary care model to achieve the goals of the SIM. Advanced primary care was defined as a patient-centered medical home model that provides patients with timely, well-organized, and integrated care.

A common measure set was created to support the implementation of the advanced primary care model. The core set of measures was designed to be shared across multiple payers and providers and to address quality issues across different regions of the state. The 2015 set includes 20 measures (all NQF-endorsed) in the domains of prevention, chronic disease, behavioral health/substance use/patient-reported, appropriate use, and cost.

The approach resulted in a focused and parsimonious set that addressed key goals of the SIM; however, including other settings and specialties could have a farther-reaching impact on reducing provider burden.

## Potential Approaches to Prioritization

The CQMC is an effort among multiple stakeholders to promote alignment in measures used by public and private health insurance providers by developing core measure sets. The CQMC is a voluntary effort in which members choose to participate and subsequently promote adoption of the core measures. Many of the efforts identified in the scan were developed to support specific models or in response to legislative requirements.

A set of principles for the core sets guides the CQMC goals in accordance with its values. While the principles provide direction, there is the potential to expand core set development into new areas as well as diversify the current core sets to include additional measurement levels or settings. To date the CQMC has chosen to focus on clinician measurement, primarily in the ambulatory care setting, and to identify measure sets that could support multiple payment models. A review of the approaches other groups have used illuminates several possibilities for how the CQMC could prioritize topics for the development of new core sets.

### *Option 1: Continue Prioritizing by Condition/Specialty*

The CQMC currently focuses on core sets that address specific conditions or medical specialties. Continuing to prioritize the creation of additional sets by specific conditions or specialty areas would allow for flexibility in targeting CQMC priorities or quality improvement needs. Additional clinical areas for core set development could be brought forward for consideration based on factors such as evidence-base, cost, prevalence, variability, improvability, disparities, burden of illness, impact on quality of life, and measure availability. Clinical areas brought forward for consideration could be compared based on well-defined factors agreed upon by the Collaborative, and the highest-ranking areas across these chosen factors could be prioritized for core set creation.

Alternatively, Collaborative members could bring forward conditions or specialty areas, and the full Collaborative could prioritize them based *solely* on group ranking/consensus opinion. The environmental scan identified a common option for prioritization: Base creation of new core sets on specific goals or priorities identified by stakeholders. As CQMC membership represents various stakeholders, using a group-ranking/consensus opinion approach to select conditions would allow the expanded work to align with current expertise and Collaborative member priorities. This approach may help sustain the

Collaborative, as the development of core sets that match member priorities could appeal to future members. Moreover, stakeholders may have varying perspectives on priorities for measurement and which factors are most important when selecting clinical areas for measurement using a core set. Using group ranking/consensus opinion allows for simpler prioritization by allowing stakeholders to weigh their own priorities or factors through their individual votes.

Continuing with prioritizing by clinical condition or specialty area would offer some advantages. First, this approach allows the CQMC to focus on the conditions of interest to its members (e.g., high cost to payers/purchasers, alignment with CQMC member expertise, conditions that have high impact on patient quality of life). This approach allows for the creation of core sets that users can apply in multiple payment or delivery models, including reporting and VBP programs. This approach does not negate a focus on cross-cutting topics, as the principles for measure selection include a criterion that promotes consideration of key cross-cutting areas for measurement. Including these measures in condition-specific sets could help highlight the need for adoption of these measures. For example, if measures addressing disparities are in the cardiovascular core set rather than in a separate disparities core set, they may be prioritized for implementation. This approach also allows the Collaborative to capitalize on the expertise of its members and could support maximum buy-in across stakeholders as clinicians may feel a greater degree of control over measures in their specialty.

However, continuing with this approach has limitations. First, focusing on certain conditions may limit the ability to include all-cause or all-condition measures in the core sets. This approach could also potentially limit the impact of CQMC efforts outside of targeted clinical areas. Certain conditions may be of utmost interest to some CQMC members, but less relevant to others. Focusing on specific clinical areas could limit the ability of some members to participate in new core set creation and to use the new core sets, and it may risk alienating members who have a broader focus. Finally, measures may not be available or in wide use for the conditions of interest to the CQMC.

If the CQMC chooses this prioritization approach, gaps that remain in high-impact, high-cost conditions that could diminish by creating a CQMC core set. The CQMC could solicit potential topic areas from all members and provide additional information to guide the Collaborative's prioritization decision. CQMC members have expressed interest in sets for behavioral health and emergency medicine. Below are examples of potential conditions and factors the CQMC could consider.

- Behavioral health/substance abuse
    - Approximate cost: Mental health and SUD treatment spending from all public and private sources is expected to total $280.5 billion in 2020, which is an increase from $171.7 billion in 2009.[14] Another estimate suggests spending of $187.8 billion in 2013.[15]
    - Impact: One in five adults experiences mental illness in a given year.[16]
    - Measure availability: NQF's portfolio currently includes 50 endorsed, behavioral health and substance use measures addressing topics such as alcohol and drug use, care coordination, depression, medication use, tobacco, and physical health.
- Neurology (examples include stroke, Alzheimer's disease, and epilepsy)
    - Approximate cost: The estimated treatment costs for neurological diseases was $101.3 billion in 2013.[15] Another study found that the cost of the nine most common neurological diseases totaled $789 billion in 2014.[17]
    - Impact: It is estimated that neurological diseases impact 100 million Americans annually.[18]

    - Measure availability: NQF's current portfolio includes 16 endorsed neurological measures addressing topics including stroke, epilepsy, multiple sclerosis, dementia and Alzheimer's disease, Parkinson's disease, and traumatic brain injury.
- Pulmonary (examples include asthma and COPD)
    - Approximate cost: The direct costs of asthma were estimated at $50.1 billion a year in 2011.[19] The total cost of asthma (including absenteeism and mortality) was $81.9 billion in 2013.[20] Costs attributable to COPD were estimated at $32.1 billion in 2010 with national medical costs projected to increase to $49.0 billion in 2020. [21]
    - Impact: 8.3 percent of Americans have asthma,[22] and 11 million Americans are diagnosed with COPD, based on a 2015 estimate.[23]
    - Measure availability: NQF's current portfolio includes 12 endorsed measures that address aspects of asthma care and 16 measures focused on care for COPD.
- Endocrine (diabetes, for example)
    - Approximate cost: The direct costs of diabetes were estimated at $237 billion in 2017, while indirect costs totaled $90 billion.[24] Another study estimated the cost of diabetes, urogenital, blood, and endocrine disorders at $224.5 billion in 2013, with diabetes costs totaling $101.4 billion.[15]
    - Impact: In 2015, it was estimated that 9.4 percent of the U.S. population had diabetes and 33.9 percent of U.S. adults had prediabetes.[25]
    - Measure availability: The NQF portfolio includes 21 endorsed measures addressing endocrine conditions. The majority focus on diabetes care.

### *Option 2: Prioritize Cross-Cutting Areas*

The majority of efforts revealed by the scan identified core sets for use in specific payment models or to assess quality of care in a specific setting or specialty. However, another option would be to focus future core sets on specific goals or priorities that cut across care settings and practice areas. For example, MAP developed sets of measures to align with the National Quality Strategy (NQS) goals. Examples of cross-cutting topic areas include care coordination/transitions of care, patient safety, access to care, appropriate use, or population health.

This approach offers potential benefits. First, creating core sets by priorities or cross-cutting areas could allow for a more holistic view of quality by focusing on key elements of care not necessarily addressed in condition-specific measures. Moreover, this approach could highlight the importance of these topics in improving healthcare quality. This approach could also allow for an assessment of care across settings, providers, and time, as well as allow for the inclusion of broader measures (e.g., all-cause or all-condition) which may not align well with the Collaborative's current framework. This approach could also help reduce measurement burden, as measures are broadly applicable across multiple providers and specialties. This approach could also keep the Collaborative's efforts more focused on set priorities.

Drawbacks to creating sets for cross-cutting areas also exist. This approach risks isolating important concepts like patient experience, disparities, and safety rather that integrating them into various clinical topic areas as central elements. In addition, the Collaborative has highlighted cross-cutting topics and priorities in its Principles for Measure Selection to ensure that available measures in these areas were considered for inclusion in each of the core sets. Using a cross-cutting prioritization approach could result in misalignment among the CQMC core sets or conflict with the principles.

If using this approach, the CQMC could solicit potential topic areas from across membership, and the Collaborative could prioritize based on group ranking/consensus opinion. CQMC members have expressed interest in core sets on disparities and patient experience.

### *Option 3: Prioritize Expanding the Current Core Sets to Address Additional Levels of Analysis and/or Settings*

Some efforts have focused on identifying core measures that work across the care continuum and address multiple care settings. To date, the CQMC's current sets mainly focus on clinician measurement in the ambulatory care setting. Various workgroups, however, have already begun to include some facility-level measures (mainly if clinician-level measures were not available), split sets between inpatient and ambulatory settings, or distinguish between measures based on whether they are intended for use in a specific payment model (e.g., ACO versus PCMH). Across workgroups, there has been interest in expanding the CQMC's focus to other care settings or levels of analysis. For example, some workgroup members expressed interest in creating separate "sets," (e.g., ambulatory care and hospital-level, each under the "Cardiology" umbrella). Additionally, workgroup members noted that hospital-level measures are increasingly being attributed to physicians and used to assess their performance.

This approach has potential benefits of its own. First, it builds upon the current sets for a more comprehensive picture of quality for a particular condition and allows for measurement across the care continuum. This approach also supports holding various clinicians and facilities responsible for the quality of an individual's care as one moves through the health system. Finally, this could allow the Collaborative to build on its existing expertise. Current workgroups already include many of the necessary experts to expand work in the existing eight areas, while still allowing for involvement of new CQMC members.

This approach also has potential disadvantages. First, it could challenge the current parsimony and focus of the core sets. Numerous measures may need to be added to address a similar topic, as measures may not be specified to cross settings or levels of analysis. For example, a measure assessing hospital readmissions may need different specifications for use in assessing hospital performance versus clinician performance. Additionally, attribution challenges could further complicate measure selection, as there may be lack of consensus as to who or which system should be accountable for an outcome. For example, health insurance provider members have expressed interest in seeing the CQMC support cost measures for the core sets, but many of the current episode-based cost measures attribute all costs for a given time period to the accountable entity of the measure. That is, a hospital may be attributed post-acute care costs, or a clinician may be attributed costs for a hospitalization.

Additionally, a measure set may address critically important issues for one setting, but not another. For example, pressure injury measures could be important to include in a safety set for inpatient settings but less applicable to an outpatient setting. Similarly, vaccination measures could be appropriate for outpatient measurement but less meaningful for inpatient settings. This variation in priorities could potentially jeopardize the efficiency and usefulness of the core sets. This approach may also delay the expansion of core sets to other clinical or cross-cutting topic areas or remove focus from promoting adoption of the current sets for programs or payment models that involve clinician measurement. Finally, this approach may overlap with the work of various other federal initiatives.

If the Collaborative prioritizes using this approach, the current core sets could potentially be expanded to include measures assessing hospitals or post-acute care providers.

## Next Steps

After a 21-day public comment period, NQF will incorporate feedback from Collaborative members and the public into the final report. Findings will be discussed with the steering committee and the full Collaborative at a future meeting, and the group will select an approach to prioritization.

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