

## Panel Discussion: *Developing Objectives for Performance Measurement for PB-TCOC Models*

### Panelists:

#### *Subject Matter Experts*

- [Cheryl L. Damberg, PhD, MPH](#) - Director, RAND Center of Excellence on Health System Performance
- [Helen Burstin, MD, MPH](#) - Chief Executive Officer, Council of Medical Specialty Societies (CMSS)
- [John B. Bulger, DO, MBA](#) - Chief Medical Officer Insurance Operations and Strategic Partnerships, Geisinger Health Plan
- [Eric C. Schneider, MD, FACP](#) - Executive Vice President, Quality Measurement and Research, National Committee for Quality Assurance (NCQA) – (Previous Submitter - The "*Medical Neighborhood*" *Advanced Alternative Payment Model* (AAPM) (Revised Version) proposal)

**Panel Discussion: *Developing Objectives for  
Performance Measurement for PB-TCOC Models***

**Cheryl L. Damberg, PhD, MPH**

Director, RAND Center of Excellence on Health System Performance

# Cheryl Damberg

- Director, RAND Center of Excellence on Health System Performance
- My background
  - Led performance measurement and shift to value-based payments by private sector employers
  - Developed and applied performance measures in practice
  - Conducted applied studies to understand:
    - impacts of incentivizing providers for their performance
    - changes providers are making in response to performance-based accountability to achieve high performance
    - challenges they face in care redesign and getting to high performance

# Designing and implementing performance measures in PB-TCOC models

- **How can performance measures be leveraged to drive delivery system transformation?**
  - Core objective is not just to measure performance, but to move health systems towards building a measurement infrastructure to monitor and improve their performance through changing care delivery
  - Measurement provides a strong signal on where to invest resources related to transformation
  - Macro level measures (e.g., total cost of care) may be sufficient and less burdensome
- **What additional measures or incentives are needed to facilitate improved outcomes among beneficiaries in PB-TCOC models?**
  - Broad set of measures to cover range of quality dimensions (avoid gaming)
  - Health equity measures tied to payments and accountability
  - Patient-reported outcomes
  - Greater shift to population-based payments with shared risk and reward

# Insights from my work

- Measures are important, but only one piece of the puzzle
  - Other strategies/tools need to be deployed in tandem to drive change
- Payment reform is happening too slowly to support transformation
  - Small amount of \$\$ at risk for most providers
  - Population-based payments needed to support care redesign and innovation
  - Value-based insurance design
- Measurement
  - Burden question (too many or too few?)
  - Outcomes are important albeit harder to measure, particularly patient-reported outcomes
  - Process measures remain important—tied to evidence-based outcomes
  - Accountability for disparities reductions and account for social risk factors in measurement
  - Patient experience is important
- Outdated processes for performance measure construction/reporting vs. future potential (i.e., EHR-based reporting)
  - To broaden what can be measured and enable more cost-effective granular reporting
- Organizational structural approaches to changing performance are needed
  - Burden on the individual doctor contributes to burnout

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**Helen Burstin, MD, MPH**

Chief Executive Officer, Council of Medical Specialty Societies (CMSS)

# Helen Burstin, MD, MPH, MACP

- Chief Executive Officer, Council of Medical Specialty Societies
- CMSS advances the expertise and collective voice of specialty societies in support of physicians and the patients they serve
  - 53 specialty society members across medicine, representing more than 800,000 physicians
  - Specialty societies develop and test quality measures; approximately 20 societies have clinical registries
- Expertise in quality and equity measurement; former Chief Scientific Officer at the National Quality Forum

# Key Takeaways

- While specialists must be accountable for measures specifically attributable to their performance, it is also critical to consider how their role is reflected in team-based population health measures
- Specialty measures that reflect appropriateness, shared decision-making, and patient-reported measures may support collaboration across time and settings in PB-TCOC models
- Consider strategies to include specialty-specific measures derived from rich clinical data in clinical registries that are developed for and by clinicians
- Accelerate the use of specialty measures that are meaningful to physicians and provide actionable information that can be used to drive improvement across patient-focused episodes



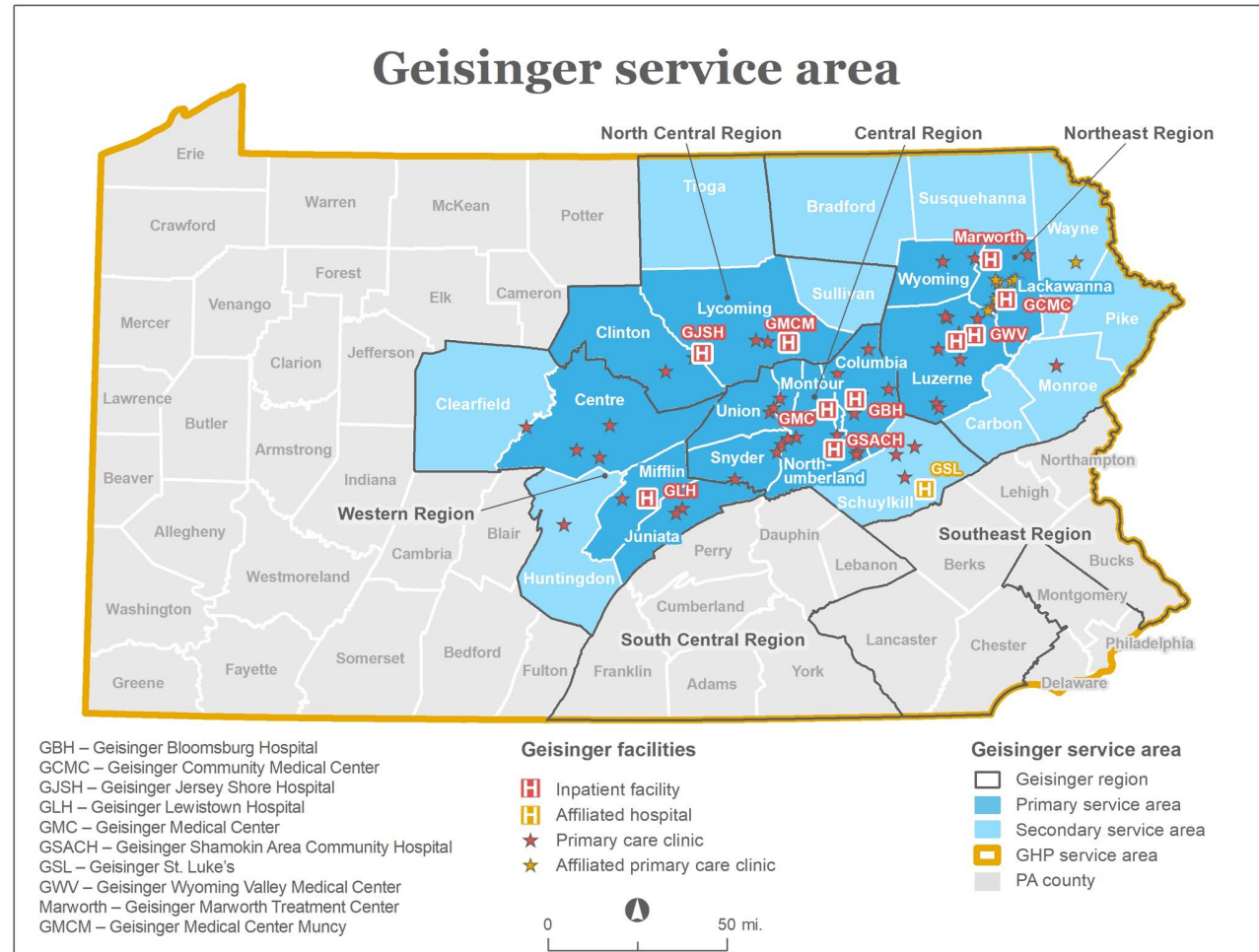
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**John B. Bulger, DO, MBA**

Chief Medical Officer Insurance Operations and Strategic Partnerships,  
Geisinger Health Plan

# John B. Bulger, DO, MBA

- Chief Medical Officer Insurance Operations and Strategic Partnership Geisinger Health
- Perspective
  - CMO, Geisinger Health Plan
  - Leader, Keystone ACO
  - Former, Chief Quality Officer of Geisinger Health
  - Former Chair, NQF CSAC



# Key Takeaways

*Keep it simple*

*Focus on outcomes*

*Recognize equity*

*Protect the public*

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**Eric C. Schneider, MD, FACP**

Executive Vice President, Quality Measurement and Research,  
National Committee for Quality Assurance (NCQA)

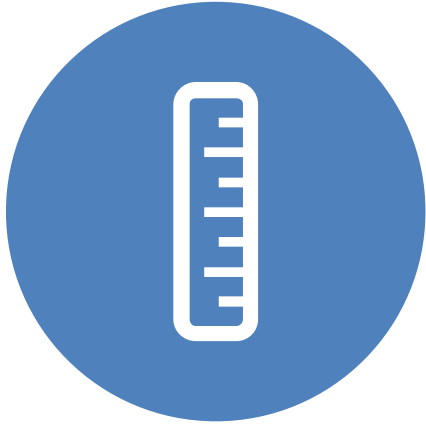
*Previous Submitter* - The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) proposal)



# Developing Objectives for Performance Measurement in Population-based Total Cost of Care Payment Models

**Eric C. Schneider, MD, FACP**  
Executive Vice President  
March 25, 2024

# NCQA's leverage for improvement



*Measure*

Health Outcomes  
Clinical Quality  
Patient Experience



*Accredit*

Health Plans  
Accountable Care  
Organizations



*Recognize*

Physician Practices  
Specialized Care Models

*Enrollment in health insurance plans that measure and report quality using HEDIS*

**203 million**

**61% of population**

**Healthcare Effectiveness Data and Information Set (HEDIS)**  
shines a light on health plans' quality

# Priorities for Performance Measurement in a Population-Based Total Cost of Care Model

- Equity
  - Reducing disparities
  - Addressing unmet social needs
- Access to Care
  - Availability
  - Timeliness
- Experience and Outcomes of Care
  - Communication and trust
  - Person-centered outcomes
- Effectiveness of Clinical Services
  - Evidence-based care/cost effectiveness
  - Safety/reliability



# Appendix

# Key Features of Population-based Total Cost of Care Payment Model

- Responsible stewardship of resources
  - Optimizes the health of a population within budgetary constraints
- Health care plus social services
  - Full scope of health-related services (clinical and social)
- Manages risk
  - Links health risk assessment to health and financial forecasting
- Rigorous monitoring to guide improvement
  - Evidence-based performance measurement and reporting

# Foundational Infrastructure for Quality Accountability in PB-TCOC Models

## *Initiatives and principles*

### **Initiatives**

- Equity-focused accountability and measurement
- Person-centered outcome measurement (goal-directed care)
- Digital quality measurement

### **Principles**

- Align accountability programs with care improvement actions
- Make measurement and reporting available in real time to support
- Leverage digital health data

# Addressing Health Equity *through Measurement*

## *Equity in HEDIS*



- **Bring transparency** to inequities in health care quality.
- **Promote inclusive approaches** to measurement and accountability.
- **Address social risks** to improve health outcomes.
- **Incentivize equity** with benchmarks and performance scoring.

<b>Social Need Screening and Intervention</b>	<b>Sexual Orientation &amp; Gender Identity</b>
<b>Social Connection</b>	<b>Disability</b> <i>(Anticipated 2024)</i>
<b>Race and Ethnicity Stratification</b>	

# To Improve Health Outcomes, Address Unmet Social Needs

## *The Argument for Health Care Intervention*



40 to 55% of health outcomes attributable to social determinants of health *outside* the traditional health care system

Black and Native American infant mortality rates 2x higher than White infants (Artiga, 2019)

Hispanic individuals 60% more likely to die from viral hepatitis than White individuals, despite lower rates of Hepatitis C (OMH, 2020).

Black, Native American and Native Hawaiian individuals receive worse care than White individuals on 4 out of 10 health care access measures (AHRQ, 2019).

From 2003 -2006, total cost of health inequities and premature death estimated at \$1.24 trillion (APHA, 2019)

In one Medicaid program, 43% of diabetes cost (\$225M) avoidable if racial & economic disparities addressed (Buescher, 2010)

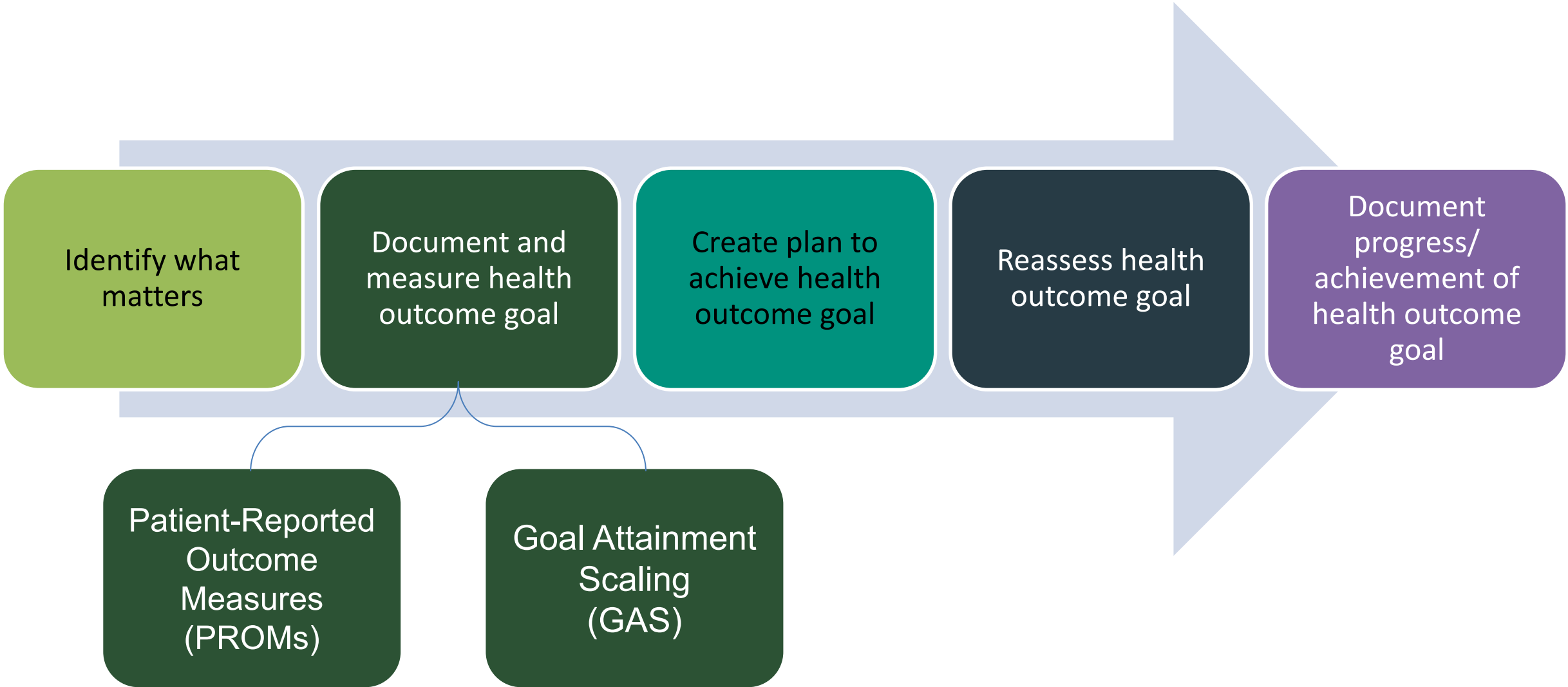
# Evaluating care that matters to people with complex care needs: Person-centered outcome measures

- For **individuals with complex care needs**, care should align with what matters to them, their health outcome goals
- **Measurement can be used to drive care that matters** and encourage clinicians to deliver care aligned with health outcome goals
- For quality measures, health outcome **goals must be measured and tracked in a standardized way**



# Person-Centered Outcomes Approach

*Measuring what individuals say matters most to them*



# Person-Centered Outcome Measures

## ***Goal Identification:***

Percentage of individuals 18 years of age or older with an identified complex care need who had a health outcome goal identified resulting in completion of a patient-reported outcome measure (PROM) or goal attainment scaling (GAS) AND development of an action plan.

## ***Goal Follow-up:***

Percentage of individuals 18 years of age or older with an identified complex care need who received documented PROM or GAS follow-up care within 180 days of action plan.

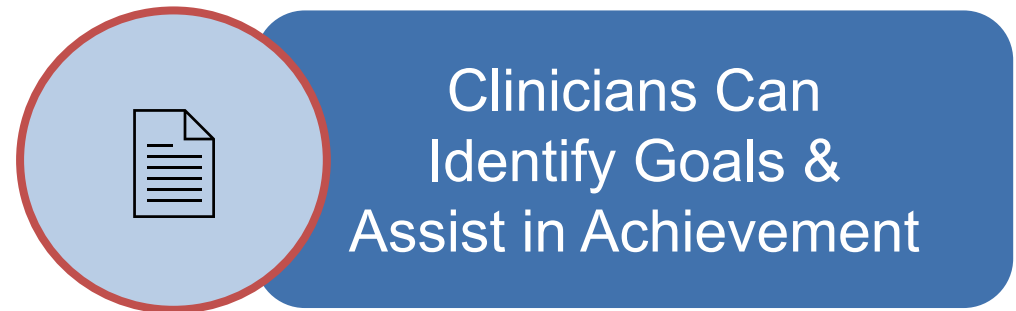
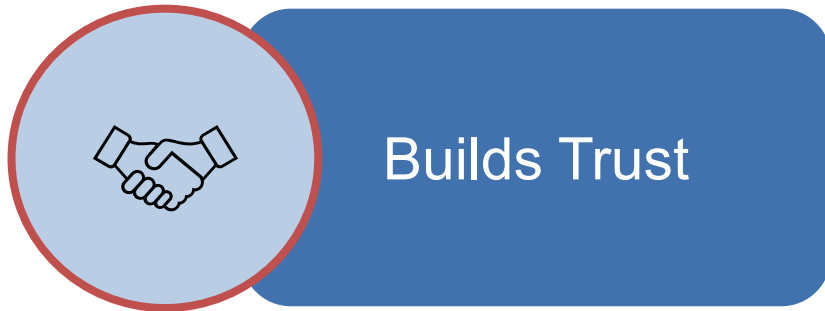
## ***Goal Progress or Achievement:***

Percentage of individuals with an identified complex care need with a documented health outcome goal (using goal attainment scaling or patient-reported outcome measure) who make progress or achieve their individualized outcome goal.



# Individual and Clinician Feedback

*Qualitative findings from those implementing the person-centered outcomes measurement approach*



# How Do We Get a Better Portrait of Quality? Add Clinical Data

*the finer brushes and colors needed to produce a higher resolution portrait of quality*



# In the 1990s, NCQA described a health information framework to support quality measurement



Essential features:

1. Data elements for measures
2. Linkage between elements and individuals' records
3. Standardized data definitions
4. Automated ("computable")
5. Data quality validation
6. Security and privacy
7. Data exchange protocols

## Enhancing Performance Measurement NCQA's Road Map for a Health Information Framework

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**M**EASURING THE QUALITY OF health care delivery is one of the most critical challenges of coming years.<sup>1</sup> The increasing effectiveness of medical treatments, unexplained variations in their use,<sup>2,3</sup> and cost-containment pressures have created an urgent need for accountability.<sup>4,5</sup> Both health plans and medical groups may respond to financial risk arrangements by limiting care and possibly undermining the quality of care. Performance measurement is one means by which we can track the quality of care that health plans and medical groups deliver.<sup>6</sup> Comparing performance and publicizing that information will drive clinicians to improve clinical care and should counter financial incentives to restrict appropriate care.<sup>7</sup>

Measuring the quality of health care delivery is one of the most critical challenges facing US health care. Performance measurement can be used to track the quality of care that health plans and medical groups deliver, but effective performance measurement requires timely access to detailed and accurate data. In 1996, the National Committee for Quality Assurance (NCQA) commissioned a report to learn what actions would improve health plans' capacity to electronically report performance data for the Health Plan Employer Data and Information Set (HEDIS). Tracking clinical performance will require not just clinical data stored in information systems, but an integrated health information framework. Seven features are essential to this framework: (1) it specifies data elements; (2) it establishes linkage capability among data elements and records; (3) it standardizes the element definitions; (4) it is automated to the greatest possible extent; (5) it specifies procedures for continually assessing data quality; (6) it maintains strict controls for protecting security and confidentiality of the data; and (7) it specifies protocols for sharing data across institutions under appropriate and well-defined circumstances. Health plans should anticipate the use of computerized patient records and prepare their data management for an information framework by (1) expanding and improving the capture and use of currently available data; (2) creating an environment that rewards the automation of data; (3) improving the quality of currently automated data; (4) implementing national standards; (5) improving clinical data management practices; (6) establishing a clear commitment to protecting the confidentiality of enrollee information; and (7) careful capital planning. Health care purchasers can provide the impetus for implementing the information framework if they demand detailed, accurate data on the quality of care.

*JAMA. 1999;282:1184-1190*

[www.jama.com](http://www.jama.com)

# The advances needed to realize the promise of digital measurement are materializing

**Computing advances**  
make complex  
analytics feasible

- Less expensive hardware
- New software capabilities
- Scalable, secure data exchange via the Internet
- Cloud computing

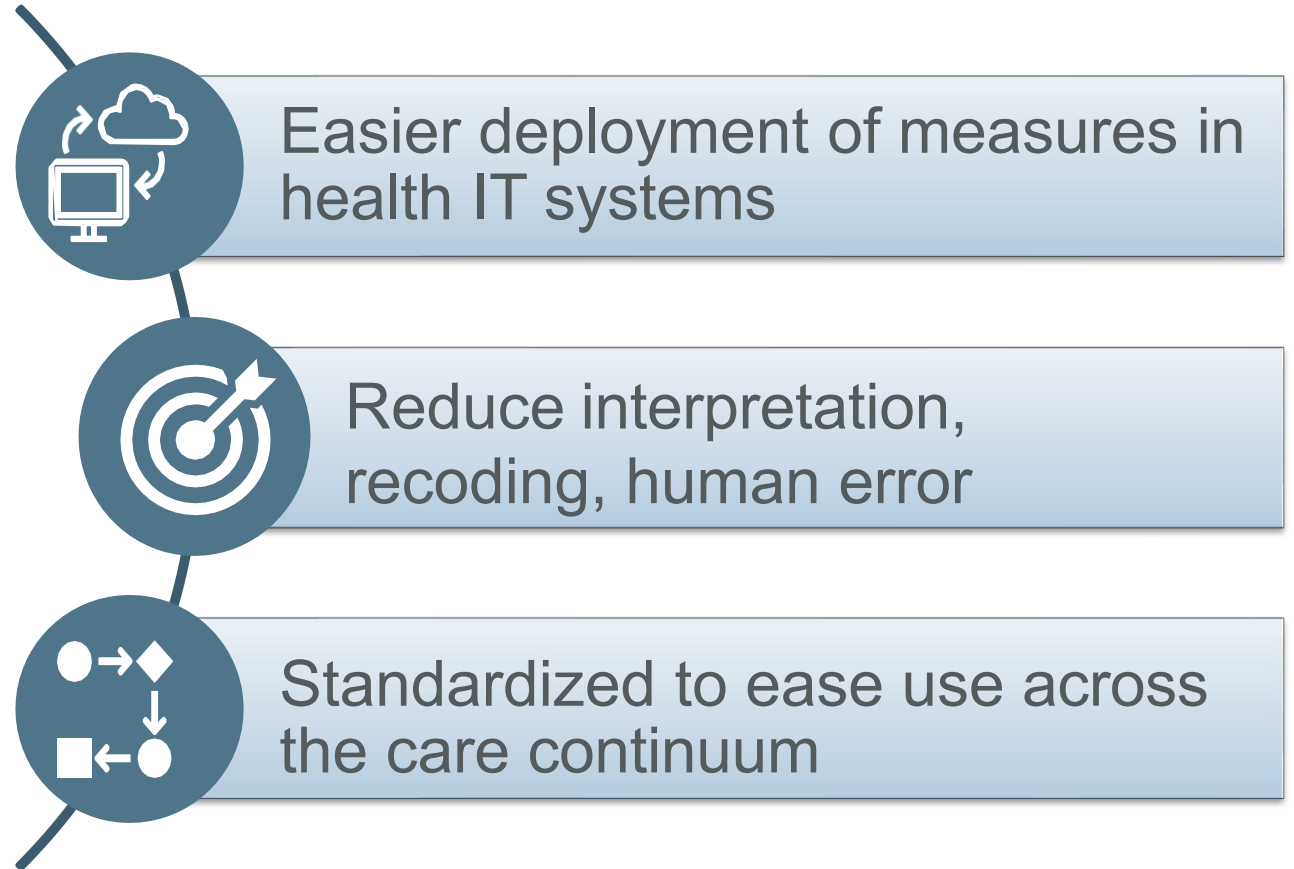
**Policy advances**  
provide the tailwinds  
for implementation

- HITECH Act provides incentives to digitize clinical information
- ACA promotes adoption of value-based care contracting
- FHIR data standards provide architecture for health data exchange
- Cures Act and ONC regulations create incentives for data exchange via Application Programming Interfaces (APIs)

# What are Digital Quality Measures (dQMs)?

## Digital quality measures:

- Use a standards-based **interoperability** format
- Source data using a **data dictionary/model** (e.g., Fast Healthcare Interoperability Resources or FHIR)
- Written in **machine-interpretable** measure logic (e.g., Clinical Quality Language or CQL)
- Incorporate **data concepts/terms** (e.g., value sets) required to **execute** the measure



# Future State: Individualizing measurement to create higher resolution portraits of quality

## Current HEDIS Measure Description

*The percentage of the cohort of women 52–74 years of age who have been enrolled in a health plan for at least two years and who have had a mammogram to screen for breast cancer every other year.*

- Does not account for variation in individual risk profiles
- Does not include women who recently changed health plans
- Does not account for patient preferences
- Does not consider the significance of positive or negative findings

## Future HEDIS Measure Description

*An individual ...*

- *Is she receiving care that matches individualized clinical risks, preferences & social needs?*
- *If risk is higher based on genetic or other data, is she receiving MRI every 6 months instead of mammogram every 2 years?*
- *What is her experience of access, timeliness, coordination and outcomes of care?*



# NCQA

Measuring quality.  
Improving health care.

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