United States Government Accountability Office

Report to Congressional Committees

October 2016

HEALTH CARE QUALITY

HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures

GAO-17-5

GAO Highlights

Highlights of GAO-17-5, a report to congressional committees

October 2016

HEALTH CARE QUALITY

HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures

Why GAO Did This Study

Both the federal government and private payers, such as health plans, increasingly use quality measures to encourage providers to improve health care quality. In addition to its ongoing programs that use quality measures to assess provider performance, HHS has proposed to begin implementing the CMS Quality Payment Program, in January 2017. However, if measures are misaligned across these programs, the misalignment could create administrative burden for providers.

The Medicare Access and CHIP Reauthorization Act of 2015 includes a provision for GAO to examine the use of quality measures across HHS programs and private payers, with a focus on reducing burden. In this report, GAO examined (1) what is known about the extent and effects, if any, of quality measure misalignment; (2) key factors that can contribute to misalignment; and (3) HHS's efforts to address any misalignment. GAO conducted a literature review to identify related studies; reviewed HHS documents; and interviewed HHS officials and experts from 16 organizations that represent a range of perspectives, including providers and payers.

What GAO Recommends

GAO recommends that HHS (1) prioritize its development of electronic quality measures and related data elements for the core measures it and private payers have agreed to use, and (2) comprehensively plan, including setting timelines for, its efforts to develop more meaningful quality measures. HHS concurred with the recommendations.

View GAO-17-5. For more information, contact A. Nicole Clowers at (202) 512-7114 or clowersa@gao.gov.

What GAO Found

While the full extent of misalignment among health care quality measures is unknown, it can have adverse effects on providers and efforts to improve quality of care. Misalignment occurs when health care payers require providers to report on measures that focus on different quality issues or define the measures using different specifications. GAO identified three studies that provided some information on the extent of misalignment. For the most part, these studies examined the number of measures that were used in common, among a narrow selection of public and private payers, and found that with few exceptions, only a small proportion of measures were commonly used by these payers. The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) agrees that misalignment exists, and some experts note that it adds to providers' administrative burden and often results in quality information that is not comparable.

GAO's interviews with HHS officials and experts indicate that three interrelated factors drive misalignment of health care quality measures, as described in the table.

Factors Driving Misalignment of Health Care Quality Measures

Factor	Description
Dispersed decision-making	Among public and private payers and other stakeholders, each entity independently decides which quality measures it will use and which specifications should apply to those measures.
Variation in data collection and reporting systems	Payers may choose different measures, modify existing measures, or leave details about measure specifications up to providers in order to accommodate differences in data that providers collect and the systems they use to collect these data.
Few meaningful measures	Although hundreds of quality measures have been developed, relatively few are measures that payers, providers, and other stakeholders agree to adopt, because few are viewed as leading to meaningful improvements in quality.

Source: GAO interviews with Department of Health and Human Services officials and experts. | GAO-17-5

HHS has various ongoing efforts that address different aspects of misalignment of quality measures and the three factors that drive it. For example, HHS has begun to address dispersed decision-making by negotiating with private payers to adopt a core set of measures. To address variation in data systems, HHS is taking steps to develop electronic quality measures—those that allow providers to report data electronically—and standardize the data collected under these measures. CMS has also taken steps to address the paucity of meaningful measures through efforts to develop new measures that focus on key quality concerns. However, HHS has not prioritized development of electronic quality measures specifically for the core measures CMS negotiated with private payers, which could delay the implementation of this alignment effort. Further, CMS has not comprehensively planned how to target the development of new, more meaningful measures that address misalignment, and it has not set timelines and methods to track its progress. Federal internal control standards and leading principles for planning call for agencies to prioritize their efforts and assess their progress in achieving their objectives. Without comprehensive planning, CMS cannot ensure that it will achieve its objective of reducing misalignment.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
CQMC	Core Quality Measures Collaborative
EHR	electronic health record
GPRA	Government Performance and Results Act of 1993
HHS	Department of Health and Human Services
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-Based Incentive Payment System
ONC	Office of the National Coordinator for Health Information Technology

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
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October 13, 2016

Congressional Committees

Both the federal government and private payers, such as health plans, increasingly use health care quality measures to encourage providers to improve health care quality. This often involves comparing the performance of physicians and other providers in order to hold them accountable for the health care they deliver and adjust their payments accordingly. For example, the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS) has several programs and initiatives that provide financial incentives to physicians and other providers based on information they report on various health care quality measures. In addition, HHS proposed to begin implementation of the CMS Quality Payment Program—a new incentive payment program for physicians and other eligible providers—in January 2017, in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[1] This program will adjust physician and other provider payments through bonuses or penalties based in part on their performance on a set of quality measures. At the same time, multiple private payers have expanded their use of different quality measures to assess physician and other provider quality and adjust their payments accordingly. The combination of these public and private efforts has led to physicians and other providers facing increased financial incentives to demonstrate high or improving performance across a growing list of diverse quality measures.

As payers increasingly rely on quality measures to inform their payments, concerns have been raised by Congress and organizations involved with quality measurement about the differences in the quality measures public and private payers require physicians and other providers to report, which we refer to as quality measure misalignment. In this report, we focus on two types of misalignment: (1) when different health care payers require providers to focus on different quality issues and, accordingly, require providers to report on different quality measures and (2) when different health care payers require providers to report on the same measure, but

[1]Pub. L. No. 114-10, § 101, 129 Stat. 87, 89 (2015).

set different specifications for that measure, such as different definitions of the measure's target population. Both types of misalignment can create administrative burdens for providers if providers must report different, sometimes highly detailed, clinical information to different public and private payers. Both types of misalignment may also make it difficult for providers to improve the quality of care they provide if the misaligned measures produce inconsistent information on the areas where the providers should focus their improvement efforts.

MACRA includes a provision for us to examine the use of quality measures across HHS programs and private payers, including the administrative burden for providers. In this report we:

1. describe what is known about the extent and effects, if any, of health care quality measure misalignment;
2. describe key factors that can contribute to quality measure misalignment; and
3. evaluate HHS's efforts to address quality measure misalignment.

To examine what is known about the extent and effects, if any, of health care quality measure misalignment, we conducted a literature review to identify relevant studies published in peer-reviewed journals, trade and association publications, conference papers, and government reports from January 2010 to February 2016.[2] We also conducted a more general internet search. As a result, we identified and reviewed 13 relevant studies.[3] (For more details about the methodology of our literature review, including our criteria for determining relevant studies, see app. I.) We examined the methodologies for each of these studies and interviewed some of their authors. We determined that the studies were sufficiently reliable for our purposes. We also interviewed HHS officials and a selection of experts from 16 organizations. We selected experts based on their relevant experience or professional qualifications to cover a range of stakeholder perspectives on quality measurement and misalignment,

[2]We selected this timeframe to ensure that we captured literature that best reflects the current state of quality measurement efforts—particularly those that may affect measure alignment—since the enactment of the Patient Protection and Affordable Care Act in 2010, which, among other things, included requirements for quality measurement.

[3]See the bibliography for a complete list of the studies we identified.

including the perspectives of providers, payers, consumers and purchasers, measure professionals, and researchers, such as the authors of two studies we identified related to the extent of misalignment.[4] We synthesized the experts' observations along with relevant literature and documents to describe what is known about the extent and effects of misalignment.

To examine the key factors that can contribute to quality measure misalignment, we used the same methodology as the one described above. Specifically, we reviewed the 13 relevant studies we identified and interviewed HHS officials and experts from the 16 selected organizations. We synthesized the information from these sources to describe the key factors contributing to the misalignment of quality measures.

To examine HHS's efforts to address quality measure misalignment, we interviewed agency officials and reviewed agency documents. We interviewed relevant officials in CMS's Center for Clinical Standards and Quality concerning their efforts to reduce quality measure misalignment in the context of their broader quality measurement efforts, including their efforts to implement the Quality Payment Program. In addition, we interviewed officials in HHS's Office of the National Coordinator for Health Information Technology (ONC) regarding their efforts to promote the development of health information technology standards related to the development of electronic quality measures. In reviewing relevant HHS documents, we focused on documents outlining HHS's plans for addressing measure misalignment in the context of the agency's broader efforts to assess provider quality performance, including the CMS Quality Strategy, the CMS Quality Measure Development Plan, and the Blueprint for the CMS Measures Management System. We also interviewed and reviewed documents from experts that provided information related to

[4]We interviewed experts from the following organizations: (1) providers—American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American College of Cardiology, American College of Physicians, American College of Surgeons, and LeadingAge; (2) payers—America's Health Insurance Plans and the National Association of Medicaid Directors; (3) consumers and purchasers—National Partnership for Women & Families and the Pacific Business Group on Health; (4) measure professionals—National Committee for Quality Assurance, National Quality Forum, and the Network for Regional Healthcare Improvement; and (5) researchers—Bailit Health Purchasing LLC, the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (previously known as the Institute of Medicine), and the RAND Corporation.

HHS's efforts to reduce quality measure misalignment. In addition, we reviewed the relevant standards for internal control in the federal government and the relevant criteria from GAO's body of work on effectively managing performance under the Government Performance and Results Act of 1993 (GPRA), as enhanced by the GPRA Modernization Act of 2010.[5]

We conducted this performance audit from September 2015 to October 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[5]Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. See GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 2014). In past reports, we have identified best practices in planning. For example, see GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act,* GAO/GGD-96-118 (Washington, D.C.: June 1996), GAO, *Combating Terrorism: Evaluation of Selected Characteristics in National Strategies Related to Terrorism*, GAO-04-408T (Washington, D.C.: Feb. 3, 2004) and GAO, *Veterans' Health Care: Proper Plan Needed to Modernize System for Paying Community Providers*, GAO-16-353 (Washington, D.C.: May 11, 2016).

Background

What are some examples of process and outcome measures related to diabetes care?

Process measures:

Hemoglobin A1c testing

- What percentage of patients with diabetes had their hemoglobin A1c tested?

Diabetes eye exam

- What percentage of patients with a diagnosis of diabetes had an eye exam?

Outcome measures:

Hemoglobin A1c Poor Control

- What is the percentage of patients with diabetes that had poor hemoglobin A1c control (HbA1c > 9%)?

Diabetes low density lipoprotein (LDL-C) control

- What is the percentage of patients with diabetes whose LDL-C was adequately controlled (<100mg/dL)?

Source: GAO review of Centers for Medicare & Medicaid Services information. | GAO-17-5

CMS and private payers use a variety of quality measures to assess different aspects of health care quality. Quality measures may be used to measure the performance of providers in various settings, including hospitals, physician offices, and nursing homes. Process measures assess the extent to which providers effectively implement clinical practices (or treatments) that have been shown to result in high-quality or efficient care, such as the percentage of patients with a myocardial infarction who receive an aspirin prescription on discharge. Others are outcome measures, which track the results of health care, such as mortality, infections, and patients' experiences of that care.

A variety of different entities may develop health care quality measures, such as the Joint Commission, the National Committee for Quality Assurance, and various medical specialty societies.[6] In some cases CMS contracts with entities for the development of measures for use in its quality programs and has established a Measures Management System Blueprint that lays out the steps measure developers should follow to first identify priority topics or conditions where new measures are needed, and then develop and test specific new measures to fill those identified gaps. According to CMS estimates, it can take 2 years or more to complete all of these steps.[7] CMS and entities that develop measures may voluntarily submit them to the National Quality Forum, a nonprofit organization that evaluates and endorses measures—that is, determines which measures should be recognized as the best available for a given aspect of care. The National Quality Forum has endorsed over 700 quality measures.

Quality measures are composed of a number of clinical data elements, or pieces of data, that are needed to calculate providers' performance on any given measure. Some measures are more complex and require more data elements. Historically, providers have collected data elements for quality measures through a detailed, manual review of paper medical records. More recently, a limited number of electronic quality measures have been developed to allow providers to report data elements

[6]The Joint Commission is a nonprofit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States, including hospitals. The National Committee for Quality Assurance is a nonprofit organization that accredits health plans and develops quality standards and performance measures for them.

[7]See Centers for Medicare & Medicaid Services, *Blueprint for the CMS Measures Management System,* version 12.0, May 2016, p. 23.

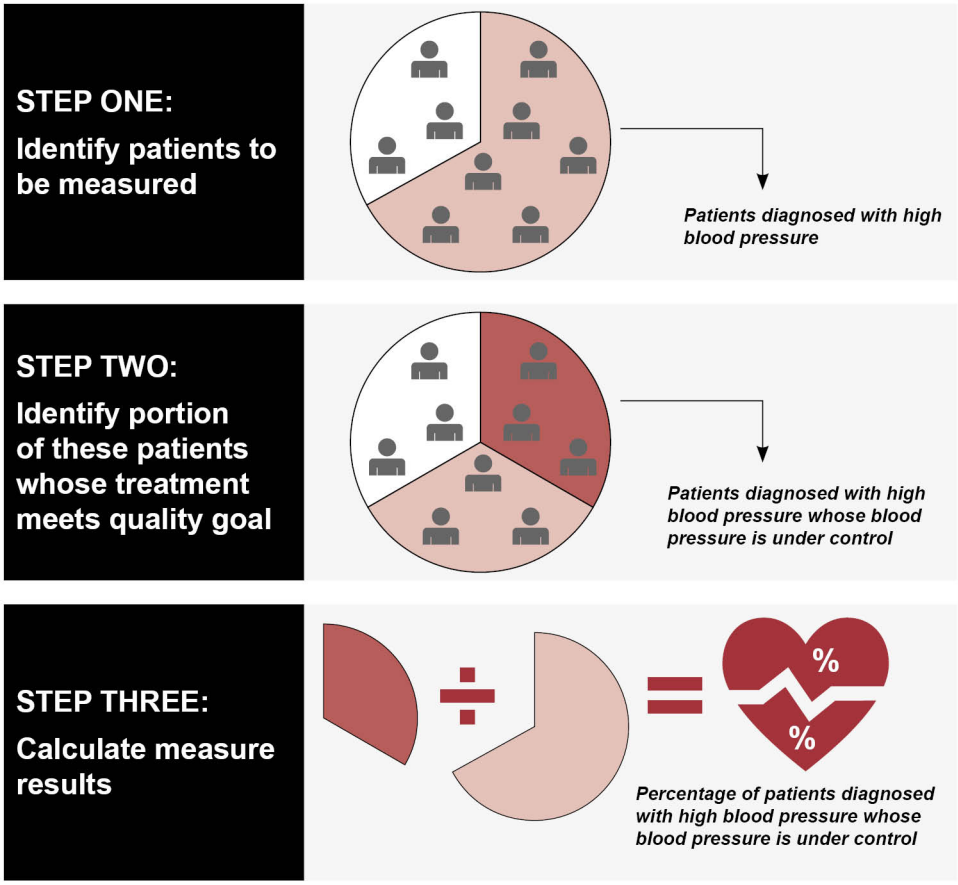
electronically using electronic health records (EHR).[8] (See fig. 1 for a general overview of how a measure, related to blood pressure control, is calculated and table 1 for examples of how the use of data elements between two blood pressure control measures can vary.)

Where do quality measures come from?

The variety of quality measures reflects the fact that many different organizations are involved in developing them. Some, such as the Joint Commission and the National Committee for Quality Assurance, develop measures to support their accreditation of hospitals and health plans, respectively. Other developers are various medical specialty societies that organize clinical data registries or other efforts to collect and analyze data on patient treatment and outcomes in specific clinical areas, such as cardiology or oncology. The organization that develops the measure is generally recognized as that measure's steward, and it controls any official changes to the measure's specifications over time.

Source: GAO review of Centers for Medicare & Medicaid Services and stakeholder information. | GAO-17-5

Figure 1: A General Overview of How to Calculate Physician Performance on Measure of Blood Pressure Control



Source: GAO interpretation of Centers for Medicare & Medicaid Services measure for controlling high blood pressure. | GAO-17-5

[8]Electronic quality measures are also referred to as electronic clinical quality measures or eCQMs.

Table 1: Examples of Data Elements Used in Measures for Controlling Blood Pressure and Variation between the Measures

Data elements	How used in the measures	Variation between two measures
Patient diagnoses	To identify patients to be included or excluded based on diagnoses	Use of different patient diagnoses to identify patients who should be included or excluded, such as whether a patient has a diagnosis of diabetes or end stage renal disease
Patient age	To identify patients to be included or excluded based on age	Inclusion of patients that range from age 18 through 75 compared to those aged 18 through 85
Blood pressure	To identify blood pressure level for patients with adequately controlled blood pressure	Blood pressure under 140/90 millimeters of mercury (mm Hg) for patients aged 18 through 75 with diabetes compared to blood pressure under 150/90 mm Hg for those aged 60 through 85 without diabetes

Source: GAO analysis of information from the Department of Health and Human Services and the National Quality Forum. | GAO-17-5

A physician or other health care provider may be required to report multiple quality measures to multiple organizations, including CMS and multiple private payers. For example, a physician may participate in Medicare and a private health plan that each use different measures for assessing the care of diabetic patients. In another example, a physician may report similar measures to multiple payers that assess blood sugar levels among diabetic patients, but each measure may use a different threshold to determine which patients have their blood sugar levels under control.

Since the early 2000's, CMS has launched a number of programs that offer financial incentives to providers receiving Medicare payments to report their performance on specified quality measures. Some of these programs, such as the Physician Quality Reporting System, are pay-for-reporting programs, in which providers may receive a mix of bonuses and penalties for simply reporting their performance on quality measures. Others, such as the Value-based Modifier program for physicians, are pay-for-performance programs, in which the level of providers' performance on the quality measures affects the amount of the payment they receive.[9] In addition, the Medicare EHR program provides a mix of bonuses and penalties to encourage hospitals and physicians to acquire EHR systems that meet certain requirements and use them in specified ways. As part of this EHR program, providers are required to use their

[9]The Value-based Modifier program uses the quality measures included in the Physician Quality Reporting System program.

certified EHR technology to collect and report certain quality measures to CMS. CMS also uses quality measures as a basis for payment in various alternative payment models—such as accountable care organizations where CMS pays groups of providers based in part on the collective performance of those providers—rather than the fee-for-service traditionally paid in Medicare.

The proposed January 2017 implementation of CMS's Quality Payment Program, in accordance with MACRA, will continue CMS's efforts to link Medicare payments with physicians' performance on various quality measures. Under this program, components of the previously separate Physician Quality Reporting System, Physician Value-based Payment Modifier program, and Medicare EHR incentive program will be merged into the Merit-Based Incentive Payment System (MIPS) so that payments for most physicians will reflect physician performance on both quality measures and EHR use. Although this new program will not start to affect physician payments until 2019, CMS has proposed that the 2019 payment adjustments will be based on physician performance on quality measures assessed during 2017. The payment adjustments will increase over time, from 4 percent in 2019 to 9 percent in 2022 and after. Payment adjustments under the program will be budget neutral, which means that the total sum of bonuses and penalties will be equal. To prepare to implement the program in 2017, CMS issued a proposed rule for the Quality Payment Program in May 2016 that included a preliminary list of the quality measures from which physicians can choose when reporting to CMS.[10] MACRA requires that CMS publish an annual list of final MIPS quality measures by no later than November 1 of the year prior to the MIPS performance period in which the measures will be used. MACRA also directed the Secretary of HHS to transfer $15 million from the Federal Supplementary Medical Trust Fund for each fiscal year from 2015 through 2019 to support measure development related to implementation of the new physician Quality Payment Program.

[10]Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule, 81 Fed. Reg. 28,161 (proposed May 9, 2016).

While the Full Extent of Quality Measure Misalignment Is Unknown, Evidence Indicates That It Increases Provider Burden and Produces Information That Is Not Comparable

Our literature review and interviews with experts indicate that the full extent of quality measure misalignment is unknown. We identified three relevant studies, but these provide only indirect information on the extent of measure misalignment. For the most part, the studies examined the number of measures that were aligned, or used in common, among a narrow selection of public and private payers and did not identify the extent of misalignment among the measures. All three studies found that with few exceptions, only a small proportion of measures were used in common by public and private payers.

- A 2015 CMS report examined the number of aligned measures used among various CMS and state Medicaid programs.[11] The study found that the percentage of aligned measures varied, ranging from 13 to 62 percent, depending on the state Medicaid program type.[12]
- A 2013 study examined the number of aligned measures used among 23 commercial health plans and in two Medicare programs, the Physician Quality Reporting System and the Medicare Shared Savings Program.[13] The study found that of the 546 quality measures used by the commercial health plans, 26—or about 5 percent—of the measures were used by more than half of the plans.[14] Further, 17 out of 301 Physician Quality Reporting System measures and 5 Medicare

[11]The report compared measures used by various CMS programs to those used by various state programs—including Medicaid—as well as to those used by Veterans Health Administration programs. Centers for Medicare & Medicaid Services, *2015 National Impact Assessment of the Centers for Medicare & Medicaid (CMS) Quality Measures Report*, (Baltimore, Md.: March 2, 2015).

[12]State Medicaid program types include Fee-for-Service, Managed Care Organizations, Accountable Care Organizations, and Dual Eligible programs, among others. See Centers for Medicare & Medicaid Services, *2015 National Impact Assessment*, 101-102.

[13]The Medicare Shared Savings Program allows providers that participate in an Accountable Care Organization to continue to receive traditional fee-for-service payments under Medicare and also be eligible for additional payments if they meet specified quality and savings requirements. See A. Higgins, G. Veselovskiy, and L. McKnown. “Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate,” *Health Affairs*, vol. 32, no. 8, (2013).

[14]Higgins, Veselovskiy, and McKnown, “Provider Performance Measures,” 1455-1456.

Shared Savings Program measures were identical to those commonly used by the commercial plans.[15]

- The third study, released in 2013, examined the number of measures that were aligned among 48 state and regional programs, including state Medicaid programs, commercial health plans, and regional collaboratives, among others.[16] The study found these programs used 509 measures, and that 20 percent of the measures were used by more than one program.[17] Medicaid Managed Care Organizations were the only type of program to share more than half of their measures.[18]

Our interviews with the authors of two of these studies helped to explain why it is difficult to determine the extent of quality measure misalignment. According to these experts, limitations in data collection and analysis make it difficult to quantify the extent of measure misalignment. For example, one of the authors said that the research team was not always able to obtain complete measure specifications from publicly available sources or measure users. Further, the specifications they did receive were often several pages long, for even just one measure, making it challenging to identify differences between the measures. The author also told us that the study was limited due to restrictions in time and funding and asserted that this type of work would be even more challenging today given the increase in the number of quality measures in use since 2013, when the study was completed.

Although CMS conducted a limited analysis of the extent of alignment as part of its 2015 study and acknowledges that misalignment exists, it has

[15]The authors did not state the total number of Medicare Shared Savings Program measures. Higgins, Veselovskiy, and McKnown, "Provider Performance Measures," 1458.

[16]Kate Bazinsky and Michael Bailit, *The Significant Lack of Alignment Across State and Regional Health Measure Sets, Health Care Performance Measurement Activity: An Analysis of 48 State and Regional Measure Sets*, (Needham, Mass.: Bailit Health Purchasing, LLC, 2013). Kate Bazinsky and Michael Bailit, *The Significant Lack of Alignment Across State and Regional Health Measure Sets: An Analysis of 48 State and Regional Measure Sets, Presentation*, (September 10, 2013).

[17]Bazinsky and Bailit, *Lack of Alignment*, 3.

[18]The six Medicaid Managed Care Organizations included in the analysis shared 62 percent of the measures used among these programs. Bazinsky and Bailit, *Lack of Alignment*, 4.

not attempted to quantify the extent of misalignment among its own programs or across public and private payers. CMS officials told us that they have not studied misalignment among their own programs because doing so would be resource-intensive, and they instead have focused resources on addressing misalignment.[19] CMS noted in its 2015 report that it has not attempted to quantify the extent of misalignment across public and private payers because findings from other studies have provided evidence regarding such misalignment.[20] Like the other studies we reviewed, these studies do not provide comprehensive information on the extent of misalignment. CMS officials told us that they felt the studies were sufficient to indicate that misalignment exists across public and private payers and needs to be addressed.

While the full extent of quality measure misalignment has not been quantified, evidence indicates that misalignment creates administrative burdens for health care providers and often results in quality information from different payers that is not comparable. This, in turn, diminishes providers' ability to identify high-impact quality improvements or prioritize the resources dedicated to them. HHS officials and one expert we interviewed observed that misalignment between federal and private payers, more than misalignment among CMS programs, may contribute to both administrative burden and quality information that is not comparable. CMS officials stated that aligning the measures used in CMS programs with the measures used by private payers and other stakeholders has the potential to provide the largest benefit. The adverse effects of measure misalignment are described in more detail below.

Administrative burden

According to a few of the experts we interviewed, quality measurement efforts require providers to expend staff time and incur administrative costs. Experts indicated that measure misalignment adds to this burden, with a few experts indicating that misalignment may be particularly burdensome among small provider practices. One expert told us that having measures with different specifications, such as different thresholds

[19]The National Quality Forum is conducting work under contract with HHS that aims to gather more information on variation of measure specifications, including identifying how, where, and why variation in quality measure specifications is occurring as well as determining the implications of such variation, among other issues.

[20]Centers for Medicare & Medicaid Services, *2015 National Impact Assessment*, 88-89, 98.

for blood sugar control levels, complicates the reporting process because providers need to compile information differently for different payers, which adds to providers' workload and disrupts their clinical workflow. Furthermore, according to a few of the experts we interviewed, small provider practices may have more difficulty devoting resources to quality measurement. Specifically, one expert said that misalignment may have a greater impact on such practices as they may not have the technology infrastructure and administrative support to collect, report, and analyze quality measure data.

Two of the studies we reviewed identified costs associated with misalignment and quality measurement more generally. A 2016 study examined the cost of quality measurement and found that 46 percent of physician practices surveyed for the study reported that it was "a significant burden to deal with measures that were similar but not identical to each other."[21] While the study did not identify specifically how much of the cost of quality measurement is attributable to misalignment, the authors reported that physician practices spent 785.2 hours per physician per year on overall quality measurement efforts, with an average annual cost of $40,069 per physician.[22] Similarly, a study published by the Institute of Medicine in 2015 noted that in a preliminary survey, 20 health care organizations reported that they may need 50 to 100 full-time equivalent employees, including physicians, at estimated costs ranging from $3.5 million to $12 million per year to support overall quality measurement efforts.[23] One expert we interviewed added that if there was greater alignment of quality measures, hospitals and other providers could save a significant amount of money.

Quality information that is not comparable

Some of the experts we interviewed also indicated that misaligned measures could result in providers receiving performance feedback from payers that is not comparable. For example, one expert told us that

[21]L.P. Casalino, D. Gans, R. Weber, et al., "US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures," *Health Affairs,* vol. 35, no. 3, (2016).

[22]Casalino, Gans, Weber, et al., "Quality Measures," 401-402.

[23]Institute of Medicine of the National Academies, *Vital Signs: Core Metrics for Health and Health Care Progress*, (Washington, D.C.: National Academies Press, 2015), 91. In March 2016, the Institute of Medicine was renamed the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine.

different payers may use measures that address the same health care issue but have different specifications—such as a different threshold for determining a patient's blood pressure level. The expert stated that with misalignment, a provider may receive feedback from one payer indicating that the provider performs adequately, while receiving feedback from another payer indicating poor performance.[24] Some of the experts indicated that this conflicting feedback in turn diminishes providers' ability to identify high-impact quality improvements or prioritize the resources dedicated to them. One of these experts told us that when providers receive this type of conflicting feedback from different payers, it makes it difficult to determine what, if any, changes they need to make to improve their performance. Further, according to one of the studies we reviewed, providers must report on large numbers of measures across different programs, resulting in "measure chaos" and inhibiting providers' ability to make focused quality improvements.[25]

Dispersed Decision-Making, Variation in Data Collection and Reporting Systems, and Few Meaningful Measures Drive Misalignment

According to HHS officials and experts we interviewed, three interrelated factors drive the misalignment of health care quality measures: (1) dispersed decision-making among various public and private health care payers regarding measures, (2) variations in the data collection and reporting systems used by providers and payers, and (3) a paucity of meaningful measures on which stakeholders can agree to align.

[24]One of the experts we interviewed told us that payers typically measure providers' performance based only on patients who are covered by that payer, rather than the provider's entire patient population. Therefore, when faced with conflicting feedback, a provider may not know if the differences are caused by misalignment, by the differing patient populations, or both.

[25]Bazinsky and Bailit, *Lack of Alignment*, 5. A few of the experts we interviewed told us that in some cases it may be reasonable for measures to differ from each other for various reasons, such as when a new or innovative measure is developed; when a different measure is needed to address a different population or priority at the regional, state, or local level; or when a measure is modified or replaced based on new scientific evidence.

Dispersed decision-making

According to HHS officials and experts we interviewed, quality measure misalignment is driven, in part, by public and private payers and other stakeholders independently deciding which measures or measure specifications to use. For example, some experts we interviewed told us that payers may prioritize different measures because they serve different populations—for example, Medicare primarily serves people over age 65, while Medicaid and private payers serve populations of various ages. In addition, payers may prioritize certain measures to focus on frequent or costly episodes of care or to differentiate themselves in competitive markets. Alternatively, physicians provide input to CMS and other payers on which measures to use and may prioritize measures focused on improving care for specific conditions they treat in their practices. Further, some experts said that even if multiple payers agreed upon a core set of quality measures at the national level, separate decisions at the state or regional level to use different measures or different measure specifications compared to those in the core sets could lead to continued misalignment.

Variation in data collection and reporting systems

HHS officials and most of the experts we interviewed agreed that measure misalignment is in part driven by the different decisions payers make to accommodate variations in the quality data that physicians and other providers collect and in the systems they use to report the data. For example, they indicated that physicians may collect the data used to calculate and report measures using different EHR systems, paper records, or clinical data registries. To accommodate these differences, experts explained that payers may choose different measures, modify existing measures, or leave details about measure specifications up to providers. While these accommodations by payers may allow providers to report on measures using the data each has available, they can also contribute to misalignment and necessitate that providers contracting with several payers produce multiple reports with different measure requirements. Furthermore, some experts told us that without common measures or measure specifications, vendors that design EHR systems for providers have little incentive to standardize their systems to facilitate the alignment of data collection and reporting.

Few meaningful measures

According to HHS officials and most of the experts we interviewed, measure misalignment is also driven, in part, by the lack of meaningful measures that payers, providers, and other stakeholders can agree should be commonly adopted. Some of these experts told us that physicians were reluctant to align with payers on measures that could not be meaningfully used to improve the quality of patient care. Despite the existence of hundreds of quality measures, experts clarified that there are

few measures that can lead to meaningful improvements in the quality of care.[26] HHS officials and experts we interviewed emphasized that certain types of measures are more likely to be meaningful, such as outcome measures. HHS officials and experts we spoke with also explained that the paucity of meaningful measures may be due to various challenges associated with developing such measures, including the lack of reliable data on which to base measures or the scarcity of resources needed for the development, testing, and validation of new measures.[27]

HHS officials and some of the experts we interviewed discussed the ways each of the three key factors driving misalignment are interrelated. For example, HHS officials and experts told us that without coordinated decisions on quality measure priorities and measure specifications, providers will continue to use incompatible systems or collect inconsistent quality data. Similarly, some experts told us that the paucity of meaningful measures is exacerbated by dispersed decision-making and different priorities among payers and other stakeholders.

[26]Authors of one study we identified found that only 27 percent of physician practices participating in the study believed that current measures were moderately or strongly representative of the quality of care. Casalino, Gans, Weber, et al., "Quality Measures," 401-406.

[27]These experts discussed the methodological challenges associated with developing measures, particularly outcome measures, such as how to attribute health outcomes to a provider when several providers were involved in a patient's care, or how quality measures account for other variables that can affect patients' health that may not be in a provider's control, such as age or socioeconomic status.

HHS Has Taken Steps to Address Quality Measure Misalignment but Lacks Comprehensive Planning to Guide Prioritization and Ensure Effective Implementation

HHS has several efforts underway that deal with different aspects of quality measure misalignment, including efforts to address the key factors that drive misalignment. However, in their efforts to develop electronic quality measures, HHS agencies have not prioritized developing such measures for the aligned core quality measures that have been adopted by both CMS and private payers. In addition, HHS has not conducted comprehensive planning for its efforts to address misalignment through the development of more meaningful quality measures, jeopardizing the effectiveness of those efforts.

Several Ongoing HHS Efforts Help to Address Misalignment and the Factors That Drive It

Based on our reviews of relevant documents and interviews with agency officials, we found that several ongoing HHS efforts help to address misalignment and the factors that drive it. Some of these efforts, such as the Measurement Policy Council and Measure Applications Partnership, focus on aligning measures across HHS programs. Others focus on developing and aligning quality measures for use by both HHS and external groups, such as private health plans and medical specialty societies. For example, the CMS Quality Measure Development Plan includes CMS's activities to promote more effective and efficient development of quality measures for its new Quality Payment Program by both HHS and external groups. In addition, the Core Quality Measures Collaborative (CQMC) focuses on aligning the measures used by CMS and private payers that assess physician quality of care. (See table 2 for more information on each effort, including which of the factors driving misalignment the effort aims to address.)

Table 2: Department of Health and Human Services (HHS) Efforts to Address Quality Measure Misalignment

HHS effort	Key activities	Factors driving quality measure misalignment that the effort aims to address
HHS Measurement Policy Council	Initiated in 2012, the Measurement Policy Council considers and strives to reach agreement across HHS agencies on selected measures to assess quality for selected conditions, such as hypertension.	Dispersed decision-making
	The Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality, and other HHS agencies have representation on the Measurement Policy Council.	
Core Quality Measures Collaborative (CQMC)	Initiated in 2014, the CQMC provides a venue for CMS and health plans to negotiate sets of core measures on which they agree to focus their physician quality performance measurement for certain conditions.	Dispersed decision-making
	Physician specialty societies, employer groups, consumer groups, and regional collaboratives have been included in the negotiations.	
CMS Quality Measure Development Plan	Issued in 2016, the Quality Measure Development Plan outlines the quality measurement activities that CMS has underway to implement the Quality Payment Program for physician payment reform.	Variation in data systems Few meaningful measures
	The Quality Measure Development Plan includes activities to facilitate the development of new measures intended to fill gaps in existing measures.	
	The Quality Measure Development Plan includes activities to facilitate development of electronic quality measures, which are measures whose specifications have been adapted to enable automated collection of data from electronic health records (EHRs).	
National Quality Forum Measure Applications Partnership	Created in 1999, the National Quality Forum evaluates and endorses quality measures, applying criteria that include a focus on harmonization—the alignment of measures with respect to their specifications—and the selection of "best in class" measures.	Few meaningful measures
	Since 2011, under contract with HHS, the forum has convened the Measure Applications Partnership to obtain external stakeholder input annually on measures that CMS is considering for inclusion in its quality programs (prior to the Secretary's ultimate decisions on which measures to include) and to identify priority areas for future measure development.	
Office of the National Coordinator for Health Information Technology (ONC)	Created in 2004, ONC has promoted data interoperability and works, for example, with the National Library of Medicine to develop and share standardized data elements that contribute to the development of electronic quality measures.[a]	Variation in data systems

Source: GAO review of HHS and National Quality Forum documents and interviews with agency officials. | GAO-17-5

[a]Standardized data elements are a type of information contained within a health information technology data system, such as an EHR, where each individual piece of information adheres to universal specifications for content, structure, and the format in which it is stored. Standardized data elements should be interchangeable without requiring translation or transformation from one quality measure or data system to another.

As shown in table 2, HHS's multiple ongoing efforts address in some way each of the factors that drive quality measure misalignment. We describe

in more detail below how these efforts work within the context of HHS's quality programs to address the factors driving misalignment.

Dispersed decision-making

HHS has taken steps to address misalignment caused by dispersed decision-making over quality measures, both among its own programs and across federal and private quality improvement efforts. From June 2012 through January 2014, HHS's Measurement Policy Council formally considered and approved seven sets of common measures, each focused on a different medical condition, for use across HHS agencies.[28] Since January 2014, the Measurement Policy Council has not approved additional sets of measures because, according to HHS officials, the focus of their alignment efforts has shifted to the negotiations conducted through the CQMC with private health plans and other external stakeholders.

Through the CQMC, HHS has begun to address directly the complaints of physicians who currently report on an array of differing quality measures to multiple private health plans as well as Medicare. Although decision-making authority remains dispersed among payers, CQMC provides a venue for HHS and private payers to negotiate on new sets of aligned measures, which include the measures that they can all agree to use in their physician quality reporting programs. In February 2016, CQMC released its first seven sets of core measures, which focus on different primary care and specialty care conditions.[29] CQMC stated that it intends to continually update these core measure sets as more meaningful measures are developed over time.

Because the CQMC has only recently released its first round of agreed-upon core measure sets, it remains to be seen how quickly and completely they will be implemented. CMS reported that changes to the

[28]The Measurement Policy Council has decided on common measures across HHS programs for the following medical conditions: hypertension, smoking cessation, depression screening, hospital-acquired conditions, HIV/AIDS, perinatal, and obesity/body mass index.

[29]These seven core measure sets focus on primary care, cardiology, orthopedics, medical oncology, obstetrics and gynecology, gastroenterology, and HIV/hepatitis C. In addition to CMS officials and representatives of the private health plans, several medical specialty societies as well as representatives of regional health collaboratives, employers, and consumers took part in these negotiations.

quality measures used in Medicare programs will continue to be made through formal rulemaking, and comparable changes in quality measures reported to private health plans will be made incrementally as the plans update or renew their contracts with different providers. While the CQMC has allowed participants to make certain decisions together, the negotiations for the initial core measure sets did not include all of the health plans, medical specialty groups, and other stakeholders involved in quality reporting programs. Moreover, limitations in available measures and the need for agreement across multiple stakeholders has, according to some experts we interviewed, led to the selection of several “lowest common denominator” measures that are not sufficiently meaningful. CMS and health plan officials acknowledge that the initial sets of core measures are just a first step, and the officials stress their interest in agreeing on more meaningful quality measures as such measures become available. Notably, each of the seven core measure sets include a list of specific topics for future measure development. According to CMS officials, these lists are intended in part to provide measure developers a guide as to what gaps in existing measures they should consider addressing in the future.

Variation in data collection and reporting systems

HHS has generally addressed variation in quality data collection and reporting systems primarily through its efforts to promote the use of EHRs for quality measurement. To reduce the burden of quality reporting for physicians and other providers, HHS has worked to develop both electronic quality measures and associated standardized data elements that will allow providers to use their EHRs to report on quality measures automatically to CMS. Implementing electronic quality measures with standardized data elements could in turn promote greater quality measure alignment to the extent that increased use of those measures leads more physicians to electronically report quality measures with uniform measure specifications. The Quality Measure Development Plan describes a number of CMS efforts that are intended to facilitate the development of electronic quality measures. CMS has developed specifications for 64 specific electronic quality measures for physicians as part of its EHR incentive program. However, HHS has noted that implementation of these electronic quality measures has been difficult in practice due in part, according to the National Quality Forum, to differences in design among EHR systems offered by different EHR vendors.

HHS is also working to simplify the task of developing and implementing electronic quality measures by promoting the development of standardized data elements across different EHR systems. This work is

led, for the most part, by ONC. ONC's efforts have focused primarily on data elements used for purposes other than quality measurement, such as exchanging patient demographic and medical history information among providers. However, according to ONC officials, ONC also provides support and resources to facilitate the development of standardized data elements needed for the development of new electronic quality measures.

Few meaningful measures

CMS has taken steps to address the paucity of meaningful measures through efforts to facilitate and streamline the development of new measures to fill identified gaps, which has the potential to allow for greater agreement on measures among CMS and private payers. Some of these efforts involve coordinating and sharing resources with measure developers working outside of government to develop new quality measures. In other cases, CMS itself leads and funds new measure development. The impending implementation of the new physician Quality Payment Program has made development of more meaningful quality measures to assess physician performance a particular priority for CMS.

The Quality Measure Development Plan outlines what CMS has done or plans to do to promote the development of new, more meaningful, quality measures for physicians under the Quality Payment Program and also to promote greater alignment across those measures. For example, the Quality Measure Development Plan describes CMS efforts to make development tools and measure testing resources available to private sector measure developers. It also describes efforts to encourage measure developers to coordinate their approach in designing new measures, such as by incorporating the same methodologies for patient risk adjustment into multiple measures. However, some of these activities are in early stages of implementation and others were launched in the last year or two, so it remains to be seen how much effect these activities will ultimately have on the development of new, more meaningful quality measures for the Quality Payment Program.

The Quality Measure Development Plan spells out a number of key considerations in selecting new measures for development. They include addressing an important medical condition or topic where there is demonstrated variation in the care offered by different providers—and therefore opportunity for improvement. To the extent that these new measures generate more useful information on how to improve care, they may also win stronger support from providers who have been skeptical of the benefit offered by previously available quality measures.

As new, more meaningful measures are developed and tested by CMS and private sector developers, CMS can promote alignment by incorporating them into its quality reporting and pay-for-performance programs for different types of providers, including physicians. Every year CMS goes through a multi-step process to consider changes to the measures used in those programs. Quality measure alignment is one of the key criteria that CMS applies in deciding which new measures to add and which measures used in prior years to drop. In making these decisions, CMS states that it aims to avoid duplication across quality. HHS contracts with the National Quality Forum to apply these criteria through the forum's measure endorsement process and to conduct the annual Measure Applications Partnership review of measures under consideration for CMS quality programs. As part of this process, the Measure Applications Partnership seeks to identify measures that are the "best available"—that is, the most meaningful—when competing measures are under consideration. Although these Measure Applications Partnership processes are limited to the particular set of measures that CMS selects for consideration in a given year, over time these decisions to add and drop measures can lead to an increasingly aligned and more meaningful set of quality measures. In addition, each year, the Measure Applications Partnership identifies priority areas for new measure development, which may help to inform CMS decisions about which new measures to promote and in which specific areas (such as cardiology or care coordination), so that more meaningful measures in those areas will be available for CMS to consider in future years.

HHS Has Not Prioritized Efforts to Develop Electronic Quality Measures for Aligned Core Measures Adopted by Both CMS and Private Payers

Although CMS and private health plans have agreed to align on the seven CQMC core measure sets, HHS has not placed a specific priority on developing electronic quality measures and associated standardized data elements for the measures included in those sets. As we described earlier in this report, both CMS and ONC have set objectives for their efforts to develop electronic quality measures that will facilitate data collection for quality measurement, and which could also have the potential to reduce misalignment. These objectives have included the creation of specific electronic quality measures that physicians and other providers may use to qualify for payments under the Medicare EHR incentive program. The objectives also include supporting the efforts of medical specialties and other organizations engaged in developing electronic quality measures. However, as of May 2016, CMS and ONC had not included in these objectives the development of new electronic quality measures for the aligned measures included in the seven CQMC core measure sets. While some of these measures already had electronic quality measure

specifications developed under the Medicare EHR incentive program, many others did not. Because CMS and private payers have agreed to align their quality measurement requirements as much as possible on the CQMC core measure sets, a growing number of physicians are likely to seek to electronically collect data to report on these measures. HHS officials stated that there was broad support within the department for promoting alignment through the implementation of the CQMC core measure sets, and that measures from those core sets will be taken into consideration when deciding which electronic measures to develop. However, the officials explained that their ability to develop new electronic measures is constrained by a number of practical limitations, such as the availability of resources and the feasibility of constructing electronic versions of certain quality measures using current EHR technology. Further, HHS officials noted that CMS is one payer among many, including a large number of private payers, which can make it more challenging to develop electronic measures.

Developing electronic quality measures and standardized data elements for all the measures in the CQMC core measure sets, when feasible, could also help HHS meet its related objective to reduce provider burden. According to HHS documents and statements by experts, quality reporting becomes easier for physicians and other providers if they have the capacity to report their performance on quality measures using their EHRs. HHS documents and statements by experts have articulated an overarching goal to create an interconnected system of EHRs that enables physicians to automatically record the needed information for quality measures as part of their normal clinical workflow, and then to report their performance to payers directly from their EHRs. According to HHS documents and statements by experts, this capability requires that each quality measure in use be specified as an electronic quality measure and that each EHR be set up to accommodate the standardized data elements required for those electronic quality measures.[30]

The recent adoption of the seven CQMC core quality measure sets by CMS and private payers creates an opportunity for CMS and ONC to

[30]Electronic health measures can be specified without standardized data elements, but in their absence implementation of the measures is much more difficult and uncertain. HHS documents note that electronic health measure specifications currently rely on complex implementation guidance that frequently is applied inconsistently across different EHRs.

focus their electronic quality measure efforts on these quality measures, which are most likely to reduce misalignment and provider burden. While CMS and ONC efforts have previously focused on different measures, federal internal controls call for agencies to respond to changed conditions by revising programs to maintain their effectiveness. To reduce misalignment and provider administrative burden and be consistent with federal internal controls, CMS and ONC would have to also take steps to prioritize their efforts to promote the development of both electronic quality measures and related standardized data elements for aligned measures that HHS and private payers have agreed to use.[31]

Without electronic quality measures and related standardized data elements for all the CQMC core measures, physicians are less likely to experience the potential benefits of easier quality reporting using EHRs, as described by HHS documents and experts. To the extent that physicians continue to face significant administrative burdens in collecting the needed quality data, they may be less likely to adopt the CQMC aligned measures. Furthermore, CMS's development of electronic quality measures for the CQMC core measure sets has the potential to address, to some extent, the difficulties posed by variation in design across EHR systems built by different IT vendors, which as previously described can impede obtaining consistent data to measure quality. Therefore, without electronic quality measures, physicians may be less able to use their EHRs to report their performance on the CQMC aligned measures to CMS and private payers. HHS would thereby miss an opportunity to reduce measure misalignment and physician burden through the automated data collection of aligned quality measures.

Lack of Comprehensive Planning Could Jeopardize CMS Efforts to Address Misalignment

CMS's efforts to develop new, more meaningful quality measures may not lead to greater measure alignment due to a lack of comprehensive planning. Increasing alignment across the measures used by federal and private payers is one of the objectives explicitly stated in CMS's Quality Measure Development Plan, but a broad range of other objectives are listed there as well. They include providing clinically relevant measures for all medical specialties; creating more measures focusing on outcomes, especially patient reported outcomes; supporting improved

[31]See GAO-14-704G.

integration of physical and behavioral health; assessing team-based care; and fully engaging the perspectives of patients and their caregivers in measure development. The plan provides no clear indication of how CMS's ongoing measure development efforts will help CMS to achieve its goal of reducing measure misalignment, such as through the development of new quality measures that are most likely to help promote quality measure alignment among federal and private payers. For example, when asked to explain the decision to develop a particular measure, CMS officials described the specific measure gap that the measure was intended to fill. However, they did not explain how developing that measure, as compared to others, would best meet the objectives outlined in the Quality Measure Development Plan, including reducing measure misalignment. Moreover, in addition to not indicating how it would address measure misalignment, CMS has not set timelines and methods for tracking its progress in meeting this objective.

CMS is nonetheless making decisions to develop specific new quality measures that will affect how well its measure development efforts address misalignment. The development, testing, and implementation of each individual quality measure require substantial time and resources. Consequently, the choices that CMS makes now on new measure development will influence its ability to meet its goal to develop measures that facilitate greater alignment. The CQMC core measure sets, which represent CMS's main effort to address misalignment across federal and private payers, provide a notable example. As noted earlier, the negotiations over alignment on the initial CQMC core measure sets were constrained by a lack of sufficient meaningful measures, and each of the initial seven core measure sets identified a list of targeted topics for future measure development for that core measure set, which have the potential to increase alignment. However, as of May 2016, CMS's Quality Measure Development Plan had not made development and testing of these CQMC-identified measures an explicit objective of CMS's measure development efforts.[32] CMS officials stated that they see some topical overlap between the quality measures they have currently under development and the topics targeted for development in the core

[32]The Quality Measure Development Plan describes CMS's support for the CQMC and its plans to continue actively participating in the CQMC, but the Quality Measure Development Plan makes no reference to addressing the measure development needs identified in the initial CQMC core measure sets.

measure sets. They also said that they intend to take the core measure sets into account in their decisions on additional new measure development. However, they have also noted that implementation of the Quality Payment Program has led to other objectives that compete for their limited measure development resources, including an objective to develop a sufficient number of quality measures that are appropriate for different medical specialties. Many of these specialties are not covered by the CQMC core measure sets.

This lack of comprehensive planning is inconsistent with federal internal control standards, which call for agencies to identify the timeframes for defined objectives and to assess their progress toward achieving their objectives.[33] Furthermore, this lack of comprehensive planning is inconsistent with leading principles on sound planning we have identified in our prior work, which call for developing robust, comprehensive plans to achieve their goals. Specifically, we have determined in prior work that sound plans include such components as what the plan is trying to achieve and how it will achieve those results, as well as priorities, milestones, and performance measures to monitor and gauge the results.[34]

Without comprehensive planning for how to target development of new, more meaningful measures that address misalignment, CMS cannot ensure that it will meet its objective to reduce measure misalignment. In particular, if CMS decisions on measure development do not address the identified needs for more meaningful measures to be included in the CQMC core measure sets, then adoption of those core measure sets is likely to be less attractive to physicians and private payers. Since adoption of the core measure sets would reduce misalignment for the physicians and payers that adopt them, slower adoption is likely to lead to slower progress in achieving measure alignment. The CQMC core measure sets represent CMS's main effort to address the misalignment of

[33]See GAO-14-704G.

[34]For example, see GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act,* GAO/GGD-96-118 (Washington, D.C.: June 1996), GAO, *Combating Terrorism: Evaluation of Selected Characteristics in National Strategies Related to Terrorism*, GAO-04-408T (Washington, D.C.: Feb. 3, 2004) and GAO, *Veterans' Health Care: Proper Plan Needed to Modernize System for Paying Community Providers*, GAO-16-353 (Washington, D.C.: May 11, 2016).

quality measures between federal and private payers—where much of the misalignment that affects physicians and other providers originates. Unless CMS targets development of new quality measures that can promote agreement on further alignment among providers and payers, the addition of new quality measures could increase, rather than decrease, misalignment by increasing the choices of available quality measures. Moreover, without setting explicit timelines and methods for tracking progress in achieving its objective to decrease misalignment, CMS cannot determine which of its efforts to develop more meaningful measures help to reduce misalignment, and which efforts need to be modified.

Conclusions

The use of health care quality measures is central to HHS's and other payers' efforts to improve health care quality. While quality measures can encourage improvements in care, they can also be burdensome to providers when the measures are misaligned and providers have to report different quality measures to different health care payers. Such misalignment has the potential to affect the success of HHS's efforts to pay providers based on the quality of care they provide. HHS has acknowledged the need to substantially improve quality measurement for physicians and other providers, and has a stated goal of improving alignment between federal and private payers.

Although HHS has initiated a range of different efforts to reduce misalignment, we identified two deficiencies in these efforts. First, HHS has not prioritized the development of electronic quality measures with standardized data elements for the core sets of aligned measures. CMS and private payers have prioritized certain quality measures to be used in common so alignment is improved, but HHS has not focused resources on developing electronic quality measures for these quality measures. As providers increasingly use EHRs, HHS has the opportunity to pursue its stated objective to develop electronic quality measures that would allow physicians to collect automatically much of the clinical information needed for these measures as part of their normal clinical workflow, with a consequent decrease in the administrative burden faced by physicians.

Second, CMS has not comprehensively planned its measure development efforts to ensure the development of new, more meaningful quality measures targeted to reduce misalignment, which could jeopardize CMS's efforts to achieve that goal. Some experts we interviewed told us that the paucity of meaningful measures makes it difficult for payers and providers to agree on aligned measures. In

contrast, developing new, more meaningful measures to replace older, less meaningful ones could help to promote further agreement on aligned measures and gain broader support from physicians. However, CMS's plans do not indicate how its efforts will target new measures that will lead to greater alignment, rather than simply adding to the array of available quality measures that has led to misalignment in the past. Achieving greater alignment will make it more likely that the efforts of CMS and private payers to hold providers accountable for the quality of their care, including CMS's Quality Payment Program, will reduce administrative burden and provide more meaningful information that providers can use to identify high-impact quality improvements.

Recommendations for Executive Action

To make it more likely that HHS will achieve its goals to reduce quality measure misalignment and associated provider burden, we recommend that the Secretary of HHS take two actions:

1. Direct CMS and ONC to prioritize their development of electronic quality measures and associated standardized data elements on the specific quality measures needed for the core measure sets that CMS and private payers have agreed to use.
2. Direct CMS to comprehensively plan, including setting timelines, for how to target its development of new, more meaningful quality measures on those that will promote greater alignment, especially measures to strengthen the core measure sets that CMS and private payers have agreed to use.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review, and HHS provided written comments, which are reprinted in appendix II. HHS also provided technical comments, which we incorporated as appropriate. In its written comments, HHS concurred with our recommendations and noted a number of its activities to help reduce quality measure misalignment. For example, as noted in our report, HHS has been working with private payers and other stakeholders to identify core sets of quality measures as part of the Core Quality Measures Collaborative. HHS stated that it has also prioritized the development of electronic measures in general. Our first recommendation focuses specifically on the need to prioritize the electronic measures included in the agreed upon core measure sets, because these measures are likely to address misalignment. HHS affirmed its intention to prioritize the development of these electronic measures, to the extent feasible, while noting some limitations with

current EHR technology that can put constraints on the development of new electronic measures.

In response to our second recommendation, HHS stated that it intends to refine planning documents to ensure that they include comprehensive planning. HHS noted that it cannot require other entities that develop measures, such as private payers, to adhere to particular timelines; however, our recommendation is for CMS to target its own development efforts on the measures that will promote greater alignment. Furthermore, as noted in our report, HHS has a critical role in quality measurement and has an opportunity to provide leadership to private payers and other stakeholders as they work to independently implement core measure sets and increase quality measure alignment.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at clowersa@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix III.

A. Nicole Clowers
Managing Director, Health Care

List of Committees

The Honorable Orrin Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Lamar Alexander
Chairman
The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Kevin Brady
Chairman
The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Appendix I: Literature Review Methodology

To examine what is known about the extent and effects, if any, of health care quality measure misalignment, we conducted a literature review to identify relevant studies published in peer-reviewed journals, trade and association publications, conference papers, and government reports published from January 2010 to February 2016, as well as a more general internet search.[1] We searched more than 25 databases for research published in relevant peer-reviewed journals, trade and association publications, and government sources, including BIOSIS Previews®, COS Conference Papers Index, Embase®, ProQuest Biological & Health Science Professional, MEDLINE®, New England Journal of Medicine, SciSearch®, and SCOPUS. Key search terms included various combinations of the terms "healthcare," "quality or performance," "measure," "align, misalign, or vary," "benchmark or impact," and "Medicare or Medicaid," among others. After excluding duplicates, we identified and reviewed 202 abstracts.

For those abstracts we found relevant, we obtained and reviewed the full study and selected nine that were relevant to (1) quantifying the extent of quality measure misalignment; (2) describing the effects of misalignment, including burden to providers; or (3) identifying the factors that contribute to misalignment. We also considered whether the studies provided insight on efforts to address quality measure misalignment. In addition to our literature review, we identified four publications through interviews with an expert and Department of Health and Human Services officials that were relevant to our report. We examined the methodologies for each of these studies and interviewed some of their authors. We determined that the studies were sufficiently reliable for our purposes. For a complete list of the studies, see the Bibliography.

[1]We selected this timeframe to ensure that we captured literature that best reflects the current state of quality measurement efforts—particularly those that may affect measure alignment—since the enactment of the Patient Protection and Affordable Care Act in 2010, which, among other things, included requirements for quality measurement.

Appendix II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

SEP 20 2016

Linda Kohn
Director, Heath Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Kohn:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"HEALTH CARE QUALITY: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures"* (GAO-17-5).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH CARE QUALITY: HHS SHOULD SET PRIORITIES AND COMPREHENSIVELY PLAN ITS EFFORTS TO BETTER ALIGN HEALTH QUALITY MEASURES (GAO-17-5)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS is committed to improving care through the development of measures that provide accurate, useful information on health care quality.

As the GAO reported, HHS has various ongoing efforts that address different aspects of misalignment of quality measures and the factors that drive misalignment. HHS is collaborating with commercial plans, Medicare and Medicaid managed care plans, purchasers, physician and other care provider organizations, and consumers through the Core Quality Measures Collaborative[1] to reduce misalignment by identifying core sets of quality measures that payers have committed to using for reporting as soon as feasible. In February 2016, HHS in conjunction with the other Core Quality Measures Collaborative participants, released seven sets of clinical quality measures.[2] These measures support multi-payer alignment, for the first time, on core measures primarily for physician quality programs. This release is the first from the Collaborative, which plans to add more measure sets and update the current measure sets over time. HHS and the partner organizations believe that by reducing the complexity for providers and focusing quality improvement on key areas across payers, quality of care can be improved for patients more effectively and efficiently.

HHS is already using measures from each of the core sets. Using the notice and public comment rule-making process, HHS also intends to implement new core measures across applicable Medicare quality programs as appropriate, while eliminating redundant measures that are not part of the core set. We expect that the participants in the Health Care Payment Learning and Action Network[3], a public-private collaboration established by HHS, will integrate these quality measures into their efforts to align payment model components with public and private sector partners.

HHS is also using new tools from the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) to support quality improvement and alignment. For example, MACRA provided additional funding to develop and implement new measures where gaps exist and to align measures with the private sector. HHS has also released a Quality Measure Development plan[4], a strategic framework for clinician quality measurement development to support the new Merit-based Incentive Payment System and advanced alternative payment models. This plan was informed by the development of the core measure sets and identification of key measure gaps. As required by law, it will be updated periodically.

HHS draws from extensive experience in these processes in conjunction with cross-agency and private-sector expertise and shares with its federal partners a commitment to promoting

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-16.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html
[3] https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/
[4] https://blog.cms.gov/2016/05/02/cms-finalizes-its-quality-measure-development-plan/

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH CARE QUALITY: HHS SHOULD SET PRIORITIES AND COMPREHENSIVELY PLAN ITS EFFORTS TO BETTER ALIGN HEALTH QUALITY MEASURES (GAO-17-5)

harmonization and alignment across programs, settings, and payers.

Recommendation #1
The Secretary of Health and Human Services (HHS) to make it more likely that HHS will achieve its goals to reduce quality measure misalignment and associated provider burden, we recommend that the Secretary of HHS take actions to:

1. Direct the Administrator of CMS and the Office of the National Coordinator for Health Technology to prioritize the development of electronic quality measures and associated standardized data elements on the specific quality measures needed for the core measure sets that CMS and private payers have agreed to use.

HHS Response
HHS concurs with GAO's recommendation. HHS has prioritized the development and use of electronic quality measures (eCQMs) and associated standardized data elements in its programs. CMS participated in the Core Quality Measures Collaborative convened by America's Health Insurance Plans (AHIP) in partnership with the NQF, clinician professional societies, and consumers and purchasers, and collaborated on the establishment of seven core quality measure sets. This multi-stakeholder workgroup will continue to develop specific core measure sets as well as monitor the implementation of the first seven sets in order to help align reporting requirements for private and public health insurance providers.

We note that of the 83 measures in the Core Quality Measures Collaborative Core Measure Sets, 30 are either already eCQMs or in development as an eCQM. Additional analysis will be needed to determine which of the remaining Core Measures are feasible to develop as eCQMs. However, it is important to note that HHS is not the sole measure developer or measure steward. HHS looks forward to additional measures developed by other measure stewards that work on eCQMs.

As GAO reported, when deciding which eCQMs to develop in the future, HHS will take into consideration measures from the core sets to the extent that the data elements that are needed to calculate the measures are captured in structured discrete fields within Certified EHR systems and there is robust technical infrastructure to thoroughly build and test the eCQMs. The lack of available discrete data elements within an EHR can put constraints on eCQM development. HHS, in conjunction with ONC, plans to explore the introduction of new data elements potentially through libraries or through avenues independent of measure specifications. To the extent feasible, HHS will work to prioritize developing eCQMs and associated standardized data elements for core measures sets agreed to by the Core Quality Measures Collaborative.

Recommendation #2
The Secretary of Health and Human Services (HHS) to make it more likely that HHS will achieve its goals to reduce quality measure misalignment and associated provider burden, we recommend that the Secretary of HHS take actions to:

2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH CARE QUALITY: HHS SHOULD SET PRIORITIES AND COMPREHENSIVELY PLAN ITS EFFORTS TO BETTER ALIGN HEALTH QUALITY MEASURES (GAO-17-5)

2. Direct the Administrator of CMS to comprehensively plan, including setting timelines, for how to target development of new, more meaningful quality measures on those that will promote greater alignment, especially measures to strengthen the core measure sets that CMS and private payers have agreed to use.

HHS Response

HHS concurs with GAO's recommendation. When measures are being developed, alignment is reviewed as a critical element for endorsement and implementation. HHS reviews both areas that need additional measure development as well as areas that may have multiple measures that need alignment. HHS will refine planning documents to ensure they include comprehensive planning and incorporate work with stakeholders on the core measures sets. It is important to note that HHS is not the sole measure developer or measure steward, and cannot require third parties to adhere to particular timelines. However, HHS will work jointly with public and private partners to further these common goals.

3

Appendix III: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Linda T. Kohn, Director; Will Simerl, Assistant Director; Amy Leone, Analyst-in-Charge; Karen Belli, Kye Briesath, Krister Friday, and Eric Peterson made key contributions to this report. Also contributing were JoAnna Berry, Vikki Porter, Lisa Rogers, and Jennifer Whitworth.

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