Core Quality Measures Collaborative
NAACOS Comments in Response to the Draft Memo, Approaches to Future Core Set Prioritization
March 22, 2019

We appreciate the opportunity to serve as a member on the Core Quality Measures Collaborative (CQMC) and to provide comments on the proposed approaches to measure prioritization. NAACOS represents more than 330 ACOs with more than 5 million lives from all 50 states and we care deeply about the issue of harmonizing quality measure sets across public and private payers for ACOs.

The CQMC currently defines a core measure set as a parsimonious group of scientifically sound measures that efficiently promote a patient-centered assessment of performance specific to a particular topic area. CQMC currently includes ACO measures in the "Accountable Care Organizations/Patient Centered Medical Homes/Primary Care" category. As the CQMC seeks to continue its work through ongoing maintenance of the existing core measure set to reflect the changing measurement landscape, we offer the following comments in regard to the three potential measure prioritization approaches.

Option One: Continue Prioritizing by Condition/Specialty

The CQMC currently focuses on core sets that address specific conditions or medical specialties and we recommend continuing this approach to obtain maximum buy-in from health insurance providers, which in turn will ease quality reporting burdens on providers. We also recommend that CQMC seek ways to incorporate cross-cutting areas within this framework, which should be identified as a quality improvement need. This approach will most effectively allow for the creation of core sets that can be easily applied in multiple payment or delivery models, reporting programs and Value Based Payment programs.

Option Two: Prioritize Cross-Cutting Areas

While we support a greater focus on cross-cutting areas, as stated above we recommend the CQMC continue its approach of prioritizing by condition/specialty. However, we also urge the CQMC to find ways to incorporate cross-cutting areas within the condition/specialty framework, as discussed in our comments above. We agree that moving to a method of prioritization that focuses on cross-cutting areas risks isolating important concepts like patient experience, disparities and safety rather than integrating them into clinical topic areas as central elements of those areas. Lastly, using this approach could result in misalignment among the CQMC core sets or reduce use of the core sets across a broad array of health insurance providers.

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

As noted in the draft memo, the CQMC's work to date has begun to include some facility-level measures, split measure sets between inpatient and ambulatory settings and distinguish between measures based on whether they are intended for use in a specific payment model, such as the ACO model. We feel this approach is most appropriate and can be continued within the current framework of prioritizing by condition/specialty. We feel moving to this approach would be too disruptive to current efforts given the complexities and potential unintended consequences such as issues with attribution which could complicate measure selection under this approach. Instead, we urge the CQMC to continue its work to include facility-level measures where appropriate and importantly, to distinguish between measures based on whether they are intended for use in a specific payment model.

We thank the CQMC for its ongoing work to promote alignment in quality measures used by public and private health insurance providers by developing core quality measure sets. We appreciate the opportunity to comment on future measure prioritization approaches and look forward to serving on the CQMC.

Sincerely,

Clif Gaus, Sc.D.
President and CEO