



## **Measures to Market Project Team**

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## **Acknowledgments**

This white paper reflects generous input and assistance from a broad range of expert stakeholders across the spectrum of health care measurement and reporting. These stakeholders highlighted the critical role that public-private partnerships must play for real change to occur. Consistent with this observation, both proposed business models include public and private collaborations as cornerstones of implementation.

Funding for the Measures to Market Project was provided by the Robert Wood Johnson Foundation

## **About the Consumer-Purchaser Disclosure Project**

The Consumer-Purchaser Disclosure Project is a coalition of more than 50 of the nation's leading consumer, labor, and employer organizations that is working to advance publicly reported, nationally standardized measures of clinical quality, efficiency, equity, and patient centeredness for health plans, hospitals, medical groups, physicians, other providers, and treatments. The Disclosure Project is supported by in-kind contributions of participating organizations and by a grant from The Robert Wood Johnson Foundation.

For more information: <http://healthcaredisclosure.org/>

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# Measures to Market

## FOREWORD

On August 22, 2006, the White House issued an Executive Order that firmly cements the federal government's commitment to improving the transparency of information on the quality and price of health care in America. The Order directs that federal purchasers, including the Medicare program, the Department of Defense, the Department of Veterans Affairs, the Indian Health Service, and the Federal Employees Health Benefits Program, require and participate in efforts to measure and report on the quality and costs of care. This may prove to be a watershed event in health care.

This white paper summarizes research results of the Measures to Market Project – conducted under the auspices of the Consumer-Purchaser Disclosure Project with funding from the Robert Wood Johnson Foundation. The Measures to Market Project was intended to speed the process of making robust information about providers' performance widely accessible. It is based on the proposition that the few business models developed by pioneers in the field of performance measurement and reporting provide guideposts to the development of a sustainable, nationwide system.

The research and analysis, conducted by the Measures to Market research team over the past 18 months, lead to two proposed business models that can serve as a basis for broad-based performance measurement and reporting. Both models rely heavily on collaboration between the public and private sectors. During the discovery process, the researchers identified "drivers of change" needed to catalyze the coordinated major steps of powerful stakeholders with incongruent and sometimes conflicting agendas. Such sparks may come from the recent Executive Order, from federal legislation, or from coordinated private-sector purchasing power.

Since the start of the project, a number of positive developments have occurred. In addition to the signing of the federal Executive Order, the formation and growing role of the AQA (formerly the Ambulatory Quality Alliance) and the recent launch of six regional pilot projects that are implementing physician-level performance measures suggest that momentum is building for a broad-based system of measurement and reporting in health care. However, this momentum could easily dissipate in the absence of concerted action.

It is our hope that this paper, by offering two related and complementary comprehensive business models, can speed the development of such a system and bring "measures to market" in the near future.



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## EXECUTIVE SUMMARY

In the past decade, performance measurement and reporting on hospitals and health plans has increased, but measurement and reporting on care provided by physicians has lagged. Despite pioneering efforts by numerous regional and national organizations, a national, standardized system of measuring and reporting in physician performance remains elusive. Some of the most successful programs have been undertaken as demonstration or pilot projects, frequently relying on short-term funding that may not be adequate or sustainable. Obtaining sustained financing for these programs has been a formidable challenge. The lack of standards and consequent inability to aggregate data among health insurers has led to performance data that are too fragmented and incomplete to serve the needs of many consumers.

To give consumers and others ready access to information on the quality and price of health care, fundamental hurdles must be overcome. These include the lack of national standardization, difficulty aggregating data from multiple payers, the limits of existing health care data, and the lack of sustainable financing.

The Measures to Market (M2M) project was designed to address these gaps by assessing the current “state of the art,” describing the multiple challenges to expansion, and developing recommendations for moving rapidly toward nationwide implementation of standardized physician performance measures and reporting in ambulatory settings. The specific M2M research objectives were to:

1. Identify the business activities necessary to promote and support physician performance measurement and reporting in ambulatory settings;
2. Identify business models for supporting these activities, and criteria for evaluating the models;

3. Analyze the strengths and weaknesses of the models;
4. Determine potential revenue streams and organizational competencies required to perform the associated work; and
5. Recommend a strategy for expanding physician performance measurement and reporting in ambulatory care.

Two topics are not addressed directly by this project: measurement and reporting of quality in non-ambulatory settings (hospitals, nursing homes, and rehabilitation facilities) and measurement and reporting of costs and efficiency of health care. These other activities are clearly important components of a national measurement and reporting strategy. They also are evolving rapidly. Lessons and principles derived from the M2M project may indeed be applicable to these other areas. However, consideration of these related topics was outside the defined scope of this project.

For the purposes of this project, a “business model” was defined as:

*“The organizational structure(s), revenue stream(s) and major expense categories for supporting business processes, products, and services related to performance measurement and reporting”*

A viable and sustainable business model was further defined as one that enabled an organization(s) to make investments and carry out one or more of the activities associated with performance measurement and reporting, while obtaining a return on investment over time. That return might merely cover the initial investment and operational costs or might yield a profit.

Five broad business activity areas were identified as key components necessary to include in a comprehensive business model for measurement and public reporting of physician performance, with each encompassing multiple steps to accomplish each activity. The five areas are:

1. Measure Development and Maintenance
2. Measure Consensus and Endorsement
3. Data Collection and Aggregation
4. Data Audit and Verification
5. Data Dissemination and Reporting

Interviews and surveys from a broad range of stakeholders were analyzed to provide data on existing and alternative models for conducting these business activities. The result of this analysis is a description of two proposed business models for enhancing measurement and reporting in the ambulatory care setting. The two models take different approaches to data collecting, aggregating, auditing, and reporting, and they have different financing strategies. Both models include significant roles for the public and private sectors, and both incor-

porate existing public and private organizations that can be leveraged to accelerate implementation.

### **Critical Requirements for Business Models**

Three “threshold criteria” were considered necessary preconditions for the business models proposed. At a minimum, acceptable models had to meet these threshold criteria:

- Can be scaled to a national level;
- Enables aggregation of data across all payers; and
- Is financially sustainable.

Analysis of stakeholder polls and surveys revealed many additional concerns. Among these were two critical requirements for proposed models:

- Protects patient confidentiality; and
- Uses transparent methods to generate results.

## Assessment of Current Business Models

Eight current business models were identified using data from interviews with stakeholders. These were evaluated as candidate models for a sustainable national performance measurement and reporting system. While each has important weaknesses relative to the three

“threshold criteria,” components of these models became building blocks for the new proposed models, reflecting the M2M team’s intent that the national business model build on successful existing programs and resources.

Business Model & Examples	Weaknesses	Adopted Features
<p>1. Health Plan Model  <b>Examples:</b>                      Numerous national and regional health plans</p>	<p>Lack of scalability nationally across multiple payers;                      Lack of standardized measures across plans</p>	<p>Operational expertise in data collection and aggregation; Reporting and dissemination</p>
<p>2. Purchaser Model (public and/or private)  <b>Examples:</b>                      Care-focused Purchasing; Massachusetts Group Insurance Commission; Maine Health Management Coalition; CMS Physician Voluntary Reporting Program</p>	<p>Lack of incentives to use standardized measures;                      Lack of aggregation across gov’t and private payers at a medical group or physician level; Business case limited to self-insured; fully insured purchasers would pay health plan(s) and data aggregator for similar/overlapping functions</p>	<p>Purchaser requirements as driver of change; Funding mechanism; Reporting and dissemination channels</p>
<p>3. State-Agency Model  <b>Examples:</b>                      Pennsylvania Health Cost Containment Council (PHC4); New York Cardiac Outcomes Model; Massachusetts - Data Analysis Center</p>	<p>Long-term financial sustainability given sensitivity to political influence; lack of standardization of measures for national scalability without federal level engagement</p>	<p>State legislation and regulation as driver of change; Mechanisms for data collection, aggregation, audit, and verification</p>
<p>4. Commercial Vendor Model  <b>Examples:</b>                      WebMD Quality Services; Subimo; Thomson/Medstat; Health Benchmarks; Resolution Health</p>	<p>Lack of standardization across measures and methods; Lack of transparency; Mostly limited to hospital-based measures; Generally lacks outpatient data for gov’t payers; Potential for redundancy and inefficiency</p>	<p>Potential for innovation; Mechanisms for audit and verification; Reporting and dissemination</p>
<p>5. Regional Quality Collaborative Model  <b>Examples:</b>                      California Cooperative Healthcare Reporting Initiative; Massachusetts Health Quality Partners; Minnesota Community Measurement; Wisconsin Collaborative for Healthcare Quality</p>	<p>Long-term financial sustainability given voluntary participation among member organizations and unstable funding mechanisms; Lack of scalability to a national level given absence of collaboratives in many markets</p>	<p>Regional responsiveness and consensus-building capability; Mechanism for all payer data aggregation, dissemination, and reporting</p>
<p>6. Accreditation/Recognition Model  <b>Examples:</b>                      NCQA; JCAHO</p>	<p>Scalability to a national level if payers do not require accreditation and majority of providers do not compete for recognition awards; Long-term viability of financial model for performance measurement activities in ambulatory settings</p>	<p>National standardization of measures; Leverage for provider participation; Potential for innovation; Consensus-building capability; Data aggregation; Analytic expertise; Reporting and dissemination</p>
<p>7. Professional Organization Certification Model  <b>Examples:</b>                      American Board of Internal Medicine; American Board of Medical Specialties</p>	<p>Lack of appropriate aggregation since measurement is MD versus patient-centric; May encourage unnecessary duplication of services; Driven by those being measured—limited stakeholder checks and balances; Limited expertise in large-scale patient-level measurement and reporting</p>	<p>National standardization of measures; Leverage for professional participation; Potential for innovation</p>
<p>8. IOM Model  <b>Example:</b>                      Proposed National Quality Coordination Board</p>	<p>Long-term financial sustainability given need for legislation and federal budget support; Privacy issues, sensitivity to political influence, need to incorporate existing stakeholder efforts</p>	<p>Federal coordinating role; Federal funding for measure development and consensus activities; Public-private leadership model</p>

## Design Principles

In addition to providing data about current business models for M2M business activity areas, the stakeholder interviews helped to generate the following Design Principles that undergird the final two models being proposed.

**National standardization and scalability:** Performance measures and specifications for implementation should be nationally standardized and made publicly available free or at little cost to assure valid comparisons across markets and reduce conflicting measurement efforts.

**Public results and transparent methods:** Valid comparative health care performance information on physicians and/or medical groups should be publicly available across all U.S. markets for use by consumers and purchasers to make informed decisions, and for use by providers to improve care.

**Public funding for standardization:** Measure development, maintenance, and consensus activities should be financed primarily through public funding in combination with private financing.

**All-payer data aggregation:** Increased data aggregation across all payers, government and private, is necessary.

**Regional and local control of data:** Both centralized and decentralized models for data collection, aggregation, and audit activities are viable.

**Minimal measurement burden:** Data collection, aggregation, and reporting processes must be designed to produce valid comparative data for consumers, providers, and purchasers while minimizing the burden and cost to providers, insurers, and the public.

**Electronic data for performance measurement:** There needs to be a planned migration away from dependence on administrative claims and chart review data to measure physician performance.

**Competitive markets for revenue-generating activities:** Free-market competition offers important roles for national and local entities to develop and improve measurement and reporting tools.

## Proposed Business Models

The M2M project analysis and Design Principles led to the development of the following two models for accelerating broad-based, sustainable performance measurement and reporting in ambulatory care: (1) the Federal Action-State Implementation Model; and (2) the Accreditation and Certification Model.

These models share a largely publicly financed “Common Foundation” for the business activities of measure development and consensus on measure standards. For the activities of data collection, aggregation, analysis, and audit, the two proposed models are distinct in their

organization, while they share a similar approach to dissemination and reporting. Although both rely on a partnership of private and public entities, the Federal Action-State Implementation Model is organized and conducted primarily by government organizations, while the Accreditation and Certification Model is organized and conducted primarily by private-sector organizations.

The following configuration shows the two business activities in which the proposed models overlap in a Common Foundation, as well as the three business activities in which they differ.

BUSINESS ACTIVITIES	BUSINESS MODELS		
1. Measure Development & Maintenance 2. Consensus and Endorsement	Common Foundation		
3. Data Collection & Aggregation 4. Audit and Validation 5. Dissemination & Reporting	<table border="0"> <tr> <td style="text-align: center; vertical-align: middle;">Federal Action-State Implementation Model</td> <td style="border-left: 1px solid black; text-align: center; vertical-align: middle;">Accreditation- Certification Model</td> </tr> </table>	Federal Action-State Implementation Model	Accreditation- Certification Model
Federal Action-State Implementation Model	Accreditation- Certification Model		

## A Common Foundation

Historically, the measure development agenda has been defined as much by the availability of funding as by national priorities for improvement. Furthermore, inadequate and unstable funding for the National Quality Forum has hampered progress in the endorsement of measure sets in priority areas and led to an opportunistic, rather than strategic, approach.

The business activities related to measure development, maintenance, consensus, and endorsement form a Common Foundation of activities that are best conducted or orchestrated by a single, independent, national organization funded through federal revenue. This is because:

- Operationally, it would be difficult it would be difficult for multiple organizations to develop a single standard.
- These activities require significant expenditures and are unlikely to produce sustained revenue.
- If financed by private-sector organizations, the production of performance measures might favor one stakeholder group at the expense of others.
- Producing and supporting a shared infrastructure of performance measurement would benefit all stakeholders.
- The resulting products (i.e., measure sets, specifications) should be placed in the public domain to ensure standardization.

While some activities would be conducted directly by this federally funded national entity, other activities (such as measure development, testing, and maintenance) may be conducted by private competing organizations that have or can readily assemble the necessary clinical and methodological expertise. These organizations would bid for contracts to conduct the work. Organizations that could do such development include medical specialty societies, accreditation organizations, academic entities, or other research organizations.

This national organization, structured as an independent public-private entity, must have the ability to effect change. It would require balanced representation by multiple stakeholders and protection from financial or political influence. The organization would ensure the occurrence of the following seven business activities, either directly or through sub-contract with private organizations:

1. Definition of a national set of priorities for measurement;
2. Measure development, testing, and evaluation;
3. Review and endorsement of a national standard set of measures;
4. Measure updating and maintenance;
5. Promulgation and ongoing review of national standards for:
  - Measure technical specifications and documentation
  - Measure testing and evaluation
  - Data collection and aggregation processes
  - Minimum competencies of potential state or regional data aggregators
  - Independent audit of measurement activities
  - Transmission of data to national aggregator
6. Calculation of national norms and benchmarks; and
7. Development and promulgation of principles for reporting performance results to both consumers and physicians/medical groups.

## Two Business Models for Data Collection, Aggregation, Audit, and Reporting

Data collection, aggregation, audit, and reporting represent the implementation arm for bringing physician performance measures to market. Currently, they are unevenly implemented across geographic areas, operate according to inconsistent standards, and suffer from inadequate and unstable funding. While a national implementation strategy

is envisioned in the two proposed models, each has a potential role for local organizations, particularly those that incorporate the participation of significant stakeholder groups.

To initiate implementation, each of the two models requires a catalyzing event that is itself the result of a “driver of change.” The proposed implementation pathways for each of the two models assume that key drivers for change are in place. While not all of the outlined steps are absolutely required to initiate implementation, they are all important to the long-term sustainability of the models.

In both models, a national public-private advisory panel would be convened to define standards functions and specifications such as data formats, data submission processes, data aggregation procedures, audit and validation standards/processes, and reporting principles (e.g., functions described by AQA in National Health Data Stewardship Board recommendations). The financing of such a panel would flow through appropriate federal agency budgets in the public sector and through accreditor organizations (from accreditation fees) in the private sector.

The independent audit function is intended to loop back to the public-private advisory panel and in turn to the measure developers. This would allow users to report implementation problems back to the measure developers.

### **Federal Action-State Implementation Model**

In this model, the federal government would serve as the initial driver of change. The catalyzing event is federal action that creates strong incentives for states to serve as the primary vehicle for conducting or contracting for the collection, aggregation, and reporting of physician performance information (based on all patients regardless of payer). Physician-level data would be rolled up and/or de-identified, and summary patient-level data submitted to the federal government for a national report card.

These federal actions could take the form of either regulatory requirements or voluntary incentives. For example, the Centers for Medicare and Medicaid Services (CMS) could

require states to participate as a condition for obtaining Medicaid matching funds or, alternatively, could offer states that engage in the program enhanced Medicaid matching funds. CMS and all federal purchasers (Department of Defense, Office of Personnel Management) could use regulatory requirements to necessitate health plan participation in state-level measurement activities as a condition of engagement in the Medicare Advantage program and could require physicians to take part in these activities as condition of participation in any federal health program. Alternatively, CMS could alter the funding formula to reward health plans and providers that participate voluntarily.

To respond adequately, payers, providers, employers, state governments, and CMS must work together to implement the performance measurement program. States may also create additional incentives for local payer and provider participation. They could make such participation a condition for licensing for health plans and providers, require participation to bid for state contracts, or offer enhanced funding under state programs for those that participate. While individual states, in the absence of federal actions, could independently act as the initial drivers for change, this approach would continue the current patchwork approach to measurement and reporting, leading only to incremental change at a national level.

### **Accreditation and Certification Model**

In this model, purchasers join together to catalyze the improvement cycle. The private and public purchaser communities collaborate with all health plan accreditors to establish physician-level performance measurement as a requirement for health plan accreditation. Health plan accreditors would require the plans to submit physician performance data from all products (HMO, POS, PPO) for public aggregated reporting. The catalyzing event would be a push by a significant majority of public and private purchasers to limit their contracts to accredited plans that participate in state or local data aggregation and reporting efforts; purchasers would gain access to publicly reported data on the majority of their insured individuals.

Specifically, the federal government in all of its purchasing functions (Medicare, Department of Defense, Office of Personnel Management) would require health plan accreditation that includes this new physician reporting expectation as a precondition for contracting. CMS could require state Medicaid plans to meet similar measurement and reporting requirements as those posed by private-sector accrediting organizations. In response to federal legislation mandating introduction of pay-for-performance programs, CMS would commit resources to expand commercial performance databases to include Medicare and Medicaid performance data. Large purchasers would work with local and national business coalitions to adopt a consensus policy requiring health plans to be accredited as a condition of doing business. Large consulting firms and broker organizations would need to recognize the value of accreditation and recommend only accredited health plans when pricing is comparable.

Additionally, physician specialty boards may require physicians to submit performance data as part of certification programs in response to health plan credentialing requirements and pay-for-performance programs. CMS could require physicians to provide data as a condition of participation in Medicare. State medical licensing boards could also require physicians to submit performance data as part of licensing requirements.

### **Dissemination and Reporting Implementation**

In the areas of dissemination and reporting activities, the two proposed models have many similarities. In both, the national public-private entity that forms the Common Foundation would set principles for the reporting of performance data to clinicians and the public (similar to those promulgated by the AQA) and disseminate the latest scientific evidence around effective reporting strategies.

States, regional data aggregators, and/or national accreditors would make data available (based on agreed-upon financial terms) to private vendors for use according to nationally established reporting principles. These vendors would compete to bring new and innovative reporting products and portals to market to support enhanced reporting activities and meet the needs of specific stakeholders. States, regional data aggregators, or health plans would also make data available to providers (based upon agreed-upon financial terms) for QI, certification, and licensure purposes.

Federal and state agencies, accreditors, regional data aggregators, purchasers, consumer organizations, health plans, medical specialty societies/boards, and/or local physician organizations will each make decisions about content for local public reporting programs. These decisions will be based on national reporting principles, nationally/locally endorsed measures, and relevant population health issues. It is expected that public and private organizations will work collaboratively wherever possible to create (or purchase from private vendors) state- and national-level public reporting programs. Both state and federally endorsed programs should meet the needs of those portions of the public that do not have access to reports through health plans, employers, or private vendors.

### **Conclusion**

Progress in widespread performance and reporting has been slow and inefficient over the past 20 years despite the independent efforts of many organizations and individuals. But there is strong cause for optimism. There is an impressive range of activities, models, and innovations in this area, and stakeholder interviews reveal coalescence behind a broad group of principles. With the right change drivers and sustainable business models, a significant acceleration of progress can be achieved.

The proposed business models might strike some readers as overly complex. This complexity reflects the mixed and multilayered nature of the U.S. health care system, its financing mechanisms, and the diverse set of stakeholder groups that have to be activated in order to produce change. Ambulatory care in the U.S. is delivered by a heterogeneous set of practices ranging from solo practitioners operating in a cottage industry model, to large organized medical groups with sophisticated internal quality management. These practices are financed by a mix of private and public payers using a variety of payment arrangements. In such an environment where multiple organizations are already involved in performance measurement and reporting, standardization and integration of existing efforts will not be straightforward.

The proposed models and their supporting rationales can illuminate promising pathways through this complexity and help jumpstart initiatives that build on them.