GAO Highlights

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

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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.