

2003-2018

The Legacy of the Consumer-Purchaser Alliance: ACCOMPLISHMENTS AND LESSONS LEARNED

For the past fifteen years, the Consumer-Purchaser Alliance has catalyzed change in the way the health care system addresses the needs of those that receive and pay for care - consumers and purchasers. The Consumer-Purchaser Alliance, a strong collaboration of leading consumer, labor, and employer organizations, has tirelessly promoted the use of performance measurement to inform consumer choice and provider payment for better outcomes, patient experience, and affordability. This innovative and groundbreaking collaboration has left an indelible mark on the health care system.

The Consumer-Purchaser Alliance created an infrastructure that allowed consumers and purchasers to exert influence on the policy landscape. Co-chaired by the National Partnership for Women & Families (NPWF) and Pacific Business Group on Health (PBGH), the Consumer-Purchaser Alliance consisted of over fifty consumer, labor, and purchaser organizations (see Appendix for participants). The unconventional collaboration of consumers and purchasers disrupted the power dynamics in health care policymaking, and their combined efforts produced results greater than their individual contributions alone.

We have made significant progress in getting a health care system that is more responsive to the needs of consumers and purchasers. Yet, more is still needed. We hope these lessons and strategies learned will inform subsequent consumer and purchaser efforts to influence health care transformation efforts.

Contents

LESSONS LEARNED	2
OVERVIEW OF ACCOMPLISHMENTS	3
APPENDIX	4
Alliance Participants	4
Key Decision-Making Bodies	5
Accomplishments	6
History & Evolving Policy Landscape	8

Lessons Learned

Reflecting on the Consumer-Purchaser Alliance accomplishments (see below), we identified the following lessons about the factors contributing to our success:

- The foremost factor has been the **power of the moral imperative**: it is hard to argue against doing the right thing for patients. This is often more effective than trying to argue about the technical aspects of performance measures and payment programs. For example, our advocacy for the use of risk adjustment for socio-demographic factors was based on the importance of not hiding the problem of disparities in care and outcomes. This tactic was more effective than trying to challenge the validity and accuracy of risk adjustment methods.
- **Building collaborative relationships** with other stakeholders made a difference to achieving advocacy outcomes. A shared understanding of each other's priorities, and really understanding where each other was coming from, created a pathway for new ways of working together. This was particularly effective in our efforts to expand the use of outcomes measures rather than process or structural measures - a goal shared by many (albeit not all) physicians, hospitals, and other providers.
- Our work also demonstrates the critical need for **support for consumers and purchasers** to effectively engage in policy deliberations alongside other stakeholders with more resources and capacity. Even the savviest and engaged consumers and purchasers have limited organizational capacity to stay current on all the critical issues. The technical support we provided was especially useful in debates regarding readmissions measures, risk adjustment for socio-demographic status, and use of patient-reported outcomes measures.
- We learned to develop and **deploy outreach and promotional efforts** to address the wide variation in technical expertise and engagement amongst our constituency, with support targeted for different levels of expertise. We have also found that education alone is often not enough and that it must be tied to an "action" or "ask" for our constituents to engage effectively.

Accomplishments

Influencing health policy is often an incremental process and requires a long-range view. In looking at our portfolio of activity, however, we can see how seemingly small victories have laid the foundation for significant changes to drive the health care system to be more responsive to consumers and purchasers. A snapshot of our accomplishments is included below. The Appendix includes a fuller description of these and other accomplishments.

➤ Increased Consumer & Purchaser Representation and Influence

The Consumer-Purchaser Alliance recruited and supported consumer, labor, and purchaser representatives for key decision-making bodies that influenced measure development, endorsement, and implementation.

Consumer-Purchaser Alliance staff provided technical support as well as political support to understand the stakeholder dynamics. This enabled representatives who had limited bandwidth and expertise to effectively participate in multi-stakeholder settings such as the National Quality Forum. Over 30 committees and hundreds of positions on these committees over the years included participants that were supported by the Consumer-Purchaser Alliance.

➤ Transformed Health Care by Incentivizing Value

Consumers and purchasers want to be able to make informed decisions on the value of care, including a more substantial role in how “value” is defined and measured – namely better health outcomes, improved care coordination and patient experience of care, and decreased costs. The Consumer-Purchaser Alliance drove change towards better value by advocating for: provider payment reforms that reward value, not volume; delivery system innovations, such as Accountable Care Organization

(ACO); and value-based purchasing. Notably, many times the Consumer-Purchaser Alliance ensured an equal focus on quality as well as cost in value-based transformation initiatives. For instance, the Consumer-Purchaser Alliance’s advocacy for the “value agenda” had a significant influence on the Bush Administration’s Executive Order (2006) as well as the Center for Medicare and Medicaid’s (CMMI’s) mission under the Affordable Care Act (ACA).

➤ Advocated for Meaningful Measures

Since 2003, meaningful measures served as the backbone of our advocacy. Our sentinel publication, *Ten Criteria for Meaningful and Usable Measures of Performance*, articulated the consumer and purchaser perspective on measure development, endorsement, and use. Some of our most notable accomplishments included the wide use of H-CAHPS (a hospital patient experience survey), the broader adoption of patient-reported outcomes (PROs) measures, and the inclusion of patient-centered measures in the health IT “meaningful use” program.

➤ Promoted Transparency and Public Reporting

Transparency of health care performance is an important form of accountability. In our early years, public reporting was more prominent in our advocacy efforts, as evidenced by the original name of the collaboration, Consumer-Purchaser Disclosure Project. Over time, we focused more on performance-based financial incentives as a critical lever to improving both quality and affordability. Nevertheless, transparency has remained a core strategy. Examples of our accomplishments in this area include public reporting of hospital-acquired conditions, implementation of consumer-friendly summary ratings of hospitals (the “star” ratings), the development of the Patient Charter to assure public reporting of physician quality, and the appropriate use of risk adjustment for socio-demographic status in performance measures.

Appendix

PARTICIPANTS*

AARP

AFL-CIO

AFT Nurses and Health Professionals

The Alliance

American Benefits Council

American Hospice Foundation

Caregiver Action Network

Carlson

Center for Medical Consumers

Childbirth Connection

Consumers' CHECKBOOK

Consumers Union

Employer Health Care Alliance

Empowered Patient Coalition

The ERISA Industry Committee

Ford

Group Insurance Commission

Health Policy Corporation of Iowa

HR Policy Association

Intel

Iowa Health Buyer's Alliance

Labor Management Health Care Coalition, Upper Midwest

The Leapfrog Group

Maine Health Management Coalition

March of Dimes

Massachusetts Group Insurance Commission

Medicare Rights Center

Memphis Business Group on Health

MidAtlantic Business Group on Health

Midwest Business Group on Health

Minnesota Health Action Group

Mothers Against Medical Error

National Breast Cancer Coalition

National Alliance of Health Care Purchaser Coalitions

National Business Group on Health

National Coalition for Cancer Survivorship

National Consumers League

National Consumer Voice for Quality Long-Term Care

National Health Law Program

National Partnership for Women & Families

National Retail Federation

New Jersey Health Care Quality Institute

Niagara Health Quality Coalition

Northeast Business Group on Health

Oregon Coalition of Health Care Purchasers

Pacific Business Group on Health

Partnership for Patient Safety

Project Patient Care

PULSE of Colorado

Service Employees International Union

St. Louis Area Business Health Coalition

UNITE HERE HEALTH

Washington Health Alliance

Wyoming Business Coalition on Health

Xerox

* Not an exhaustive list

EXAMPLES OF KEY DECISION-MAKING BODIES

National Quality Forum (NQF)

- ▶ Board of Directors
- ▶ Consensus Standards Advisory Council
- ▶ Consumer Council
- ▶ Purchaser Council
- ▶ Measures Application Partnership
- ▶ Over 15 Steering Committees on Measure Endorsement
- ▶ At least 30 Committees on Measurement Issues

Health Care Payment Learning and Action Network (HCP-LAN)

- ▶ Guiding Committee
- ▶ Alternative Payment Model Framework
- ▶ Alternative Payment Model Measurement
- ▶ Alternative Design & Implementation
- ▶ Consumer Affinity Group
- ▶ Purchaser Affinity Group

Health Care Transformation Task Force (HCTTF)

- ▶ Board of Directors
- ▶ Accountable Care Organizations
- ▶ Bundled Payments
- ▶ Path to Transformation Advisory Group
- ▶ Patient-Centered Priorities Workgroup
- ▶ Public Policy Advisory Group

Core Quality Measures Collaborative (CQMC)

- ▶ Steering Committee
- ▶ Accountable Care Organizations
- ▶ Obstetrics and Gynecology

Ambulatory Quality Alliance (AQA)

- ▶ Steering Committee

Hospital Quality Alliance (HQA)

- ▶ Principals
- ▶ Staff

Stand for Quality

National Committee for Quality Assurance (NCQA)

HIT Policy Committee

ACCOMPLISHMENTS

➤ Increased Consumer and Purchaser Representation & Influence

One key example is the Consumer-Purchaser Alliance's role in the National Quality Forum (NQF), which is a multi-stakeholder consensus standard setting organization for performance measures. The Board and committee structure of NQF was carefully designed to ensure consumers and purchasers could have the appropriate level of influence, and the Consumer-Purchaser Alliance advocated successfully to preserve these structures and ensure continued consumer/purchaser influence. For example, our advocacy served as the catalyst for a new policy requiring endorsed measures to be publicly reported within two years (or risk losing NQF endorsement status). Similarly, we significantly influenced NQF's revised Measure Evaluation Criteria to prioritize consumer and purchaser concerns. NQF remains a leader in performance measure endorsement and consumer and purchaser perspectives continue to play a prominent role

Over time, other stakeholder groups formed multi-stakeholder alliances as an alternative to the NQF process. For example, the Hospital Quality Alliance (HQA) was formed to select from the pool of NQF endorsed measures which ones it would recommend. Some of the NQF endorsed measures supported by the Consumer-Purchaser Alliance did not receive HQA adoption, where consumers and purchasers were a minority. The AQA, Ambulatory Quality Alliance, was another multi-stakeholder organization focused on measures for physicians. The federal government had recently launched physician measurement programs and the AQA was trying to be a consensus entity for those programs. Unfortunately, many of the measures initially brought to AQA just assessed basic competence, not clinical outcomes or patient experience. Consumers and purchasers teamed up with health plans to stop the preponderance of "low bar" measures in AQA and drive better standards for quality measures.

➤ Transformed Health Care by Incentivizing Value

The Consumer-Purchaser Alliance influenced important health care policies of the Bush Administration, such as an Executive Order, to: (1) change the early focus solely on price to encompass total episode costs; (2) expand payment rewards to encompass providing consumers with tools and incentives; and (3) replace the narrow focus on health savings accounts with consumer and provider incentives.

The Consumer-Purchaser Alliance also informed the Obama Administration's health care reform initiatives. Through its coalition-building, advocacy, education, and technical assistance, the Consumer-Purchaser Alliance prepared consumer and purchaser communities to effectively advocate for reform that embraced quality and value as a foundation of care delivery. Our imperative to move towards a system of accountability that is performance-based and patient-centric gained significant momentum. Our activities were vital to ensuring the Affordable Care Act addressed not only coverage, but also delivery system reform. For instance, the Center for Medicare and Medicaid Innovation's (CMMI) original mission was only focused on reducing costs. The Consumer Purchaser Alliance made sure the Center also focused on maintaining or improving quality, and the models tested included patient experience and other patient-centered measures.

➤ Advocated for Meaningful Measures

The Consumer-Purchaser Alliance leadership was integral to ensuring a hospital patient experience survey, H-CAHPS, was NQF endorsed and ultimately built into national public reporting systems. Prior to H-CAHPS, multiple patient satisfaction and patient experience surveys were used by hospitals. Private survey vendors worked fiercely to keep it this way and protect their proprietary business. The Consumer-Purchaser Alliance facilitated two years of persistent efforts, that included organizing comment letters to the Secretary of Health and Human Services, working with local communities, educating members of Congress, briefing the Office of Management and Budget, and mobilizing consumers and purchasers to engage in federal rulemaking. These efforts generated results. Not only was H-CAHPS endorsed by NQF, but our efforts to educate policymakers about the importance of patient-centered measures created a climate conducive to proposals for Medicare to establish financial incentives for hospitals to collect and publicly report standardized patient experience information. Today, patient experience is a core measure across federal and private sector value purchasing programs.

The Consumer-Purchaser Alliance also worked diligently to advance the use of patient-reported outcomes (PROs) for care improvement and performance reporting. Some of our most notable activities included:

- ▶ Working with large payers to address barriers and foster adoption of PROs through value-based purchasing programs.
- ▶ Working with the Office of the National Coordinator for HIT and CMS to require PROs in the Quality Payment and Electronic Health Record Incentive programs.
- ▶ Serving on expert panels to promote development and assessment of PRO performance measures, prioritize person-centered care and outcomes measures as a component of a national quality strategy, and advance PRO measures in new payment and delivery models.
- ▶ Engaging with sponsors of clinical registries to encourage them to incorporate PROs.

The Consumer-Purchaser Alliance also helped to shape federal health IT policy following the passage of the American Recovery and Reinvestment Act (ARRA). Against significant resistance, we successfully advocated for the “meaningful use” of strong, patient-centered measures in the EHR Incentive Program. In recent years, we continued to advocate for robust health IT requirements in Medicare payment policies and accountability programs. In particular, we advanced policies that promote patient access to their information and consumer/clinician interoperability.

➤ Promoted Transparency and Public Reporting

In 2006, there was a growing trend of doctors filing complaints with their state Attorneys General about unfair treatment by health plans which used opaque methodologies in their physician rankings as a cost control mechanism. In New York, Attorney General Andrew Cuomo was planning to abolish physician ranking programs in the name of protecting consumers. The Consumer-Purchaser Alliance convinced Cuomo that closing these programs would be a grave disservice to consumers and instead encouraged the AG to improve the programs. Our advocacy framed the terms of the agreement between the New York Attorney General and major national health plans that promoted a balanced approach to assuring validity of physician measurement efforts, while not unduly impeding their expansion. The Consumer-Purchaser Alliance engaged forty-two consumer, purchaser, physician, and health plan organizations to develop and adopt a national Patient Charter for Physician Performance Measurement Reporting and Tiering Program in 2007. NCQA served as deeming body to certify plans were appropriately conducting physician rankings in New York. Subsequently, C-P Alliance supported regional roll-outs in Illinois, Missouri, Tennessee, Wisconsin, Maryland, and Maine.

In the development of the Hospital Compare website, consumers and purchasers advocated for reporting of measures important to consumers and purchasers and displaying information that highlights meaningful differences. With the Physician Compare website, we expanded this advocacy to include reporting at the most granular level possible.

In 2014, CMS unexpectedly stopped reporting data for eight hospital-acquired conditions (HACs). In response to strong pushback from consumers and purchasers, CMS reversed this decision and has continued to make data for these eight conditions available through the CMS website for researchers and advocates to use.

The move to star ratings to indicate performance on available quality measures and an overall score published on CMS’ Hospital Compare website garnered significant opposition. We activated our network to express public support and informed lawmakers of the joint consumer-purchaser perspective, ultimately leading to their successful implementation.

One particularly challenging issue in public reporting was the proposal to use sociodemographic status (SDS) to risk adjust measures. NQF convened a Technical Expert Panel to guide how it should be considered. Consumers and purchasers had a shared belief that performance measurement should enhance our ability to identify and eliminate disparities. On the one hand, we did not want SDS risk adjustment to obscure our ability to see differences in outcomes. On the other hand, we also concerned about the unintended consequences of using outcome measures in accountability strategies that could result in additional harm to disadvantaged populations by inappropriately penalizing providers working with these populations. We led efforts to redirect from adjusting the measures to a more constructive approach that recognized the different costs of caring for low SDS groups, without locking in place existing disparities.

HISTORY OF C-P ALLIANCE & THE EVOLVING POLICY LANDSCAPE

Pre-ACA (2003-2010)

Fifteen years ago, a small group of consumer and purchaser organizations met to discuss forming a collaboration around performance measurement and its use in public reporting. In the year following that meeting, the collaboration met regularly and increased its participation to close to twenty organizations. Over time, that number would continue to grow. When it first started, the collaboration was called the Consumer-Purchaser Disclosure Project (CPDP). Because of this collaboration, there was a growing recognition of the importance of these perspectives in national health policy.

The Consumer-Purchaser Disclosure Project focused on getting better standardized measures for clinical quality, consumer experience, and resource use to include in public reports to inform selection of providers and public accountability. During this time, the proliferation of measurement initiatives increased the need to have ready and able consumer and purchaser representation. Yet those that receive and pay for care were consistently under-represented and ill-equipped to adequately advance their perspective in influential health care forums. Many consumers and purchasers did not have the expertise and resources necessary to effectively advocate for the faster adoption of meaningful measures and their use in value purchasing. This was in stark contrast to many organizations – hospitals, physician groups, health plans, and accreditors – for which health care is their core business, allowing them to bring significant internal expertise and resources to advance their interests. Without a consumer and purchaser voice at the table, the only perspective would have been that of those being measured. Initially, the few dozen consumer and purchaser representatives serving on national policy-making and advisory bodies had minimal support and limited expertise. Over time, CPDP built the capacity of its constituents and demand for their expertise.

CPDP worked with its constituents to provide “behind-the-scenes” technical expertise and political strategy to develop and advocate for positions in key decision-making bodies. At both national and state levels, the few years leading up to passage of the Affordable Care Act provided a significant opportunity to expand access to health care for the millions of un- and underinsured Americans. Given the well documented quality problems, including disparities in care that are unrelated to coverage, “access to what” was a parallel question raised by CPDP. The Consumer Purchaser Disclosure Project created messages that linked quality and costs to access, including arguments to counter the attempts to characterize the performance measurement efforts as “anti-consumer” and similar to managed care or the patient’s bill of rights. These messages were incorporated into testimony, discussions with policymakers, and project materials. In certain circles these messages were eventually “fed back to us”, providing evidence that we were making headway on this important issue.

Affordable Care Act Era (2010-2014)

In the years leading up to health care reform, the idea that health care performance information should be available on all providers had reached the “tipping point”. There was widespread agreement that public reporting and value-based purchasing were key to improving health care. We had to deal with accusations of “death panels,” fears over rationing care, concerns with implementing health information technology, and claims that physician ratings are inaccurate – all within the context of a rapidly changing political environment that was pushing for major reform. To address these challenges, we used a variety of techniques including mobilizing consumers and purchasers, responding in the media, counteracting the messages with policymakers, and revising our messaging to address concerns.

In 2010, the historic passage of the Affordable Care Act (ACA) catalyzed health care reform that addressed not only coverage but also delivery system reform. Through its coalition-building, advocacy, education, and technical assistance, the Consumer-Purchaser Disclosure Project prepared consumer and purchaser communities to be effective advocates for health care reform that embraces quality and value as the new foundation of care delivery. Once the ACA became law, the value agenda in federal programs moved forward at an unprecedented pace. Recognizing value-based purchasing and payment reform had grown central to the consumer, labor, and consumer agenda, the collaboration changed its name to the Consumer-Purchaser Alliance.

MACRA Era (2015 to Present)

Physician payment reform, and namely addressing the perverse incentives of fee-for-service payment and the Sustainable Growth Rate (SGR) formula, represented the unfinished business of ACA. Since 1997, 17 short-term fixes to the SGR were implemented during



year-end legislation. Efforts to replace the SGR were unsuccessful until the Medicare Access and Chip Reauthorization Act (MACRA) was passed in 2015. MACRA represented meaningful progress towards paying physicians for value, not volume.

A year later, the new Administration and leadership in Congress launched efforts to repeal the Affordable Care Act. In a highly charged political landscape, federal access and coverage policies took center stage. The value agenda still required attention and effort, yet many of our constituents were dedicating nearly all their attention to coverage issues. For the first time since our forming, we observed a conspicuous absence in federal leadership promoting the value agenda. Although we lost significant momentum, we continued the push for performance measurement, value-based payment, and new models of care. We are encouraged by the recent steps the current leadership of CMS has taken to re-invigorate the movement toward high-value payment and care models, but we recognize that a strong consumer and purchaser influence is needed to keep moving forward.

ABOUT THE CONSUMER-PURCHASER ALLIANCE

The Consumer Purchaser Alliance is a collaboration of leading consumer, employer and labor groups working together to promote the use of performance measurement in health care to inform consumer choice, value-based purchasing, and payment. Funded by the Robert Wood Johnson Foundation, along with support from participating organizations, our mission is to strengthen the voice of consumers and purchasers in the quest for higher quality, more affordable health care.