



Supporting Payment and Delivery System Reform through Multipayer Quality Measure Alignment:

Lessons from State Innovation Models

June 24, 2019

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About SHADAC

- SHADAC is a multidisciplinary health policy research center with a focus on state policy. Affiliated with the University of Minnesota, School of Public Health, SHADAC faculty and staff are nationally recognized experts on collecting and applying health policy data to inform policy decisions, with expertise in both federal and state survey data sources. Learn more at shadac.org.
- SHADAC also provides technical assistance to states that received State Innovation Model — or “SIM” — awards from the Center for Medicare & Medicaid Services to accelerate health care transformation as part of a team led by NORC at the University of Chicago that serves as the SIM Resource Support Contractor. SHADAC and other technical assistance partners support states and the Center for Medicare & Medicaid Innovation (CMMI) in designing and testing multi-payer health system transformation approaches.

Speakers

CMMI

- *Allison Pompey, DrPH*
Director, Division of State Innovation Models
- *Jennifer Lloyd, PhD*
Evaluation Lead, SIM Round 1
- *Greg Boyer, PhD*
Evaluation Lead, SIM Round 2

SHADAC

- *Colin Planalp, MPA*
Senior Research Fellow, SHADAC

Washington

- *Bonnie Wennerstrom*
Healthier Washington Connector, Washington Health Care Authority
- *Laura Pennington*
Practice Transformation Manager, Washington Health Care Authority
- *J.D. Fischer*
Manager, Value-Based Purchasing, Washington Health Care Authority

Webinar Agenda

- **Overview of State Innovation Models (SIM)**
- **Multipayer Quality Measure Alignment**
 - A strategic framework drawn from SIM States' experiences
 - State highlight: Washington Statewide Common Measure Set
 - Measure alignment lessons from SIM evaluations
- **Question and Answer Session**
 - Please submit questions via the chat feature

Overview of State Innovation Models

Allison Pompey, DrPH

Director, Division of State Innovation Models (SIM)
Center for Medicare & Medicaid Innovation (CMMI)

Multipayer Quality Measure Alignment: A Framework Drawn from SIM Experiences



Colin Planalp, MPA
Senior Research Fellow
SHADAC

Developing a Common Measure Set

- Determining an alignment strategy
- Articulating a rationale
- Setting an alignment scope
- Engaging a workgroup
- Identifying measure selection criteria
- Inventorying and evaluating measures
- Selecting measures
- Sustaining alignment

Determining an Alignment Strategy

Voluntary vs. Mandatory Alignment

Voluntary strategy

- Commercial payers encouraged, but not required, to align with a common measure set

Mandatory strategy

- Commercial payers are required to align with a common measure set

Determining an Alignment Strategy

Mandatory strategy

- Leveraging statutory or regulatory authority to mandate commercial payers align with a common measure set
- Employing negative or positive mandates on commercial payers' use of quality measures



Determining an Alignment Strategy

Voluntary strategy

- Building buy-in through stakeholder engagement
- Using state purchasing authority to “jump start” a common measure set (e.g., adopt in Medicaid, public employee benefits, etc.)



Determining an Alignment Strategy

Minnesota

- Statutory negative mandate
- Prohibits commercial insurers from requiring providers to report on measures excluded from the common measure set



Source: <https://www.revisor.mn.gov/statutes/2008/cite/62U.02>

Determining an Alignment Strategy

Rhode Island

- Regulatory positive mandate
- Requires commercial payers to use measures from common measure set in any value-based payment arrangements



Source: <http://www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf>

Articulating a Rationale

Setting goals for quality measure alignment

- What do stakeholders seek to accomplish by aligning quality measures? Examples:
 - Reducing provider burden
 - Furthering shift to value-based payment
 - Promoting quality transparency to consumers

Making the case to stakeholders

- When and how to set alignment rationale, as a tool for engaging stakeholders? Options:
 - Before stakeholder process —
to persuade stakeholders to join the effort (i.e., “sales pitch”)
 - During the stakeholder process —
to ensure goals reflect stakeholder priorities (i.e., develop buy-in)

Articulating a Rationale

Minnesota

- Authorizing statute set goals:
 - Contain provider burden
 - Promote quality transparency



Source: <https://www.revisor.mn.gov/statutes/2008/cite/62U.02>

Articulating a Rationale

Connecticut

- Stakeholder workgroup set guiding principle that common measure set should:
 - “assess the impact of race, ethnicity, language, economic status, and other important demographic and cultural characteristics important to health equity”



Source:

http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/quality/report/qc_report_11102016_final.pdf

Setting an Alignment Scope

What payers and programs could be covered?

- **Payers:** Public payers (e.g., Medicaid, state employee plans, etc.), commercial payers
- **Programs:** Value-based payment programs (e.g., PCMHs, ACOs, etc.), transparency programs (e.g., public quality reports or websites)

What levers may be employed?

- Contracting levers (e.g., Medicaid managed care contracts)
- Regulatory levers (e.g., regulatory requirements for commercial plans)

Setting an Alignment Scope

Washington

- Use of common measure set in required in state purchasing of health care (e.g., Medicaid, employee health benefits)



Sources:

<http://lawfilesexternal.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf>

<https://www.hca.wa.gov/assets/Washington-State-Common-Measure-Set-2018.pdf>

Engaging a Stakeholder Workgroup

Roles of a stakeholder workgroup

- Solicit input from relevant constituencies
- Identify and establish shared priorities
- Cultivate stakeholder buy-in for effort

Select stakeholders and convening entity

- Convening entity (state agency vs. trusted non-state entity)
- Stakeholder workgroup members

Measure set authority

- What entity holds authority over the measure set?
 - Workgroup
 - State agency

Common workgroup members

Commercial payers

Public payers

(e.g., Medicaid, public employee benefits)

State agencies

(e.g., insurance department, health department)

Health care providers

(e.g., hospitals, physicians)

Consumers

(e.g., individuals, advocacy orgs.)

Others

(e.g., labor unions, private employers, quality measurement experts)

Engaging a Stakeholder Workgroup

State	Workgroup convener	Measure set authority
Connecticut	State agency	Workgroup
Massachusetts	State agency	State agency
Minnesota	Third party	State agency
Rhode Island	State agency	State agency
Washington	Third party	Workgroup

Engaging a Stakeholder Workgroup

State Agency Conveners

- **Connecticut:** Office of Health Strategy, State Innovation Model office



- **Massachusetts:** Department of Public Health and Center for Health Information and Analysis



- **Rhode Island:** Office of the Health Insurance Commissioner



Engaging a Stakeholder Workgroup

Third-party conveners

- **Minnesota:** Minnesota Community Measurement (not-for-profit quality measurement organization)
- **Washington:** Washington Health Alliance (not-for-profit operator of voluntary APCD)



Identifying Measure Selection Criteria

Purpose of measure selection criteria

- Allows a systematic evaluation of available quality measures
- Prevents arbitrary decisions that could undermine stakeholder confidence

Common selection criteria

Opportunity for improvement

(e.g., gap between actual and optimal performance, performance variation across providers)

Proven/consensus measures

(e.g., preference for National Quality Forum-endorsed measures, evidence-based measures that are reliable and valid, availability of benchmarks)

Containing burden

(e.g., practicality/feasibility of data collection, prioritization of claims vs. self-reported data)

Measure type

(e.g., preference for outcome over process measures)

Inventory and Evaluation of Measures

Develop an inventory of measures under consideration

- Measures currently used by payers in the state
- Other measures for consideration (e.g., opioid measures)

Assessing existing alignment

Measure	Payer 1	Payer 2	Payer 3	Alignment score
Diabetes				
Hemoglobin A1c (HbA1c) testing		X		1
Hemoglobin A1c (HbA1c) control (<8.0%)	X	X		2
Hemoglobin A1c (HbA1c) poor control (>9.0%)			X	1
Preventive screenings				
Colorectal cancer screening	X	X	X	3

Inventory and Evaluation of Measures

Evaluate measures according to selection criteria

- Score measures according to how well they meet selection criteria

Evaluating candidate measures

Measure	NQF endorsed	Room for improvement	Outcome over process
Diabetes			
Hemoglobin A1c (HbA1c) testing	X		
Hemoglobin A1c (HbA1c) control (<8.0%)	X	X	X
Hemoglobin A1c (HbA1c) poor control (>9.0%)	X	X	X
Preventive screenings			
Colorectal cancer screening	X	X	

Selecting Measures

Weighting selection criteria

- Should certain criteria be weighted more heavily than others when selecting measures?

Measurement priorities and goals

- Does the state have certain measurement priorities (e.g., diabetes, substance use disorder) or goals (e.g., reducing disparities, promoting transparency) that should be considered in measure selection?

Measure sub-sets

- Measure sets are commonly organized into different sub-sets

Measure set stewardship authority

- What entity has ultimate authority over the measure set?

Selecting Measures

Measurement priorities and goals

- **Rhode Island:** Adopted measure of appropriate opioid prescribing in response to priority of opioid crisis
- **Connecticut:** Investigating ways to quantify disparities in quality measures to goal of improving health equity



Selecting Measures

Measure Sub-sets

- **Massachusetts:** Sub-sets for different provider types — Physician Group/Practice, Hospital, Post-Acute
- **Rhode Island:** Sub-sets of “core” measures for mandatory use and “menu” measures for optional use
- **Connecticut:** Sub-sets of “core” measures for payment, “reporting” for public reporting only, and “development” for future consideration



Selecting Measures

Measure Set Authority

- **Rhode Island:** Office of the Health Insurance Commissioner, with workgroup recommendations
- **Connecticut:** Quality Council stakeholder group
- **Minnesota:** Department of Health, with workgroup recommendations



Sustaining Common Measure Sets

Preventing measure sets from becoming stale

- Without regular updates, common measure sets can lose effectiveness for multiple reasons:
 - Providers may “top out” in performance improvement
 - Evidence changes, supporting measures themselves or the practices they promote
 - Feasibility of measures may change (e.g., allowing a shift from claims-based to clinical quality measures)
 - Quality priorities may evolve over time
- States commonly revise measure sets with an annual process, addressing:
 - Retirement of measures and adoption of new measures
 - Re-evaluation of measurement priorities

Sustaining Common Measure Sets

Preventing measure sets from becoming stale

Washington

- Added new measures of appropriate opioid painkiller prescribing align with new quality priorities



Washington Statewide Common Measure Set



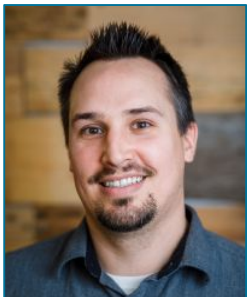
Bonnie Wennerstrom, MSW, MPH

Healthier Washington Connector, former SIM Project Director
Washington State Health Care Authority



Laura Pennington

Practice Transformation Manager
Washington State Health Care Authority



J.D. Fischer, MPH

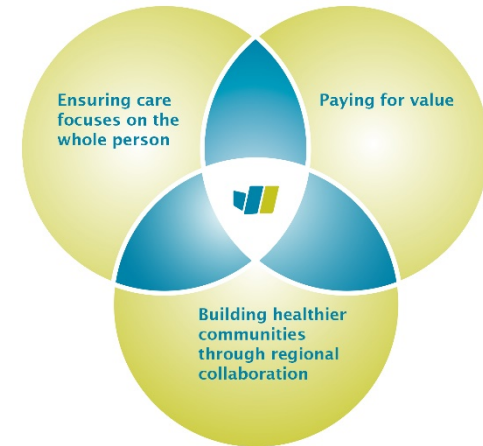
Value-based Payment Manager
Washington State Health Care Authority

Healthier Washington

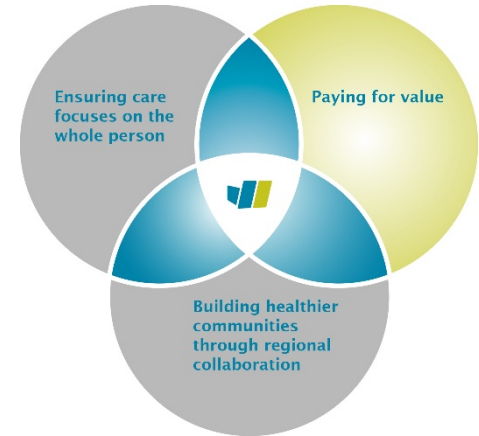


Many different strategies, with many public and private partners

- Accountable Communities of Health
- Paying for value
- Performance measures
- Practice transformation support hub
- Shared decision making
- Integrated physical and behavioral health
- Analytics, interoperability, and measurement
- A plan for improving population health
- Health workforce innovation



Paying for Value



Washington State Common Measure Set on Health Care Quality and Cost

Washington State Common Measure Set, 2019 (PMCC Approved, December 2018)

The following 46 measures are appropriate for **Population Health Monitoring AND Value-Based Contracting for Payment**.

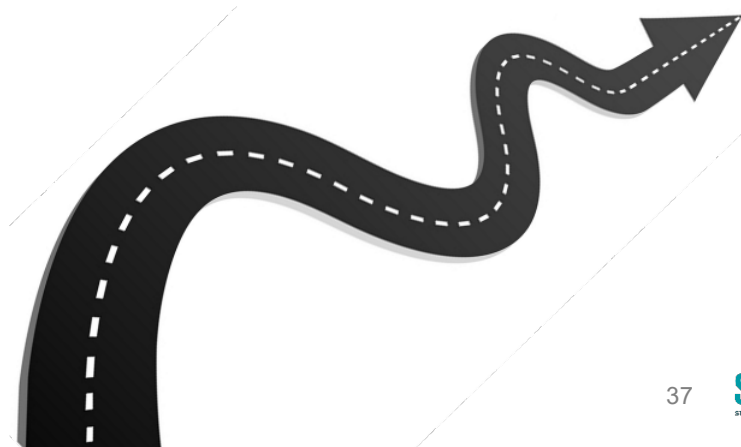
#	Measure Name	Measure Steward ¹	NQF-Endorsed	Type of Data	Data Source in WA ²	Measure Description	Required Units for Public Reporting in 2019				
							State	Counties/ACHs	Health Plans ³	Medical Groups/Clinics ⁴	Hospitals
IMMUNIZATIONS											
1	Childhood Immunization Status (CIS) Combination 10	NCOA (HEDIS)	Yes 0038	IIS Registry	DOH	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTap); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Yes	Yes	Yes		
2	Immunizations for Adolescents (IMA)	NCOA (HEDIS)	Yes 1407	IIS Registry	DOH	The percentage of children 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. Report: (1) Combination Rate 2; (2) HPV for Female Adolescents; and (3) HPV for Male Adolescents	Yes	Yes	Yes		
PRIMARY CARE AND PREVENTION - CHILDREN/ADOLESCENTS											
3	Children and Adolescents' Access to Primary Care Practitioners (CAP)	NCOA (HEDIS)	No	Claims	APCD	The percentage of members 12 months - 19 years of age who had a visit with a PCP. Report four separate rates: 12-24 months of age; 25 months - 6 years of age; 7-11 years of age; 12-19 years of age.	Yes	Yes	Yes		
4	Oral Health: Primary Caries Prevention Offered by Primary Care	HCA	No	Claims	HCA	Total number of patients (Age ≤ 6), who received a Fluoride Varnish (FV) application during a routine health visit with any non-dental health care provider who has received the appropriate training to apply FV. Measured and reported for Medicaid insured population only.	Yes	Yes	Yes - MCOs only		
5	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	NCOA (HEDIS)	Yes 0024	Claims and Clinical	Health Plans ³	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: (1) BMI percentile documentation; (2) counseling for nutrition; and (3) counseling for physical activity. Report three separate rates.	Yes		Yes		
6	Well Child Visits in the First Fifteen Months of Life (W15)	NCOA (HEDIS)	Yes 1392	Claims	APCD	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	Yes	Yes	Yes	Yes	
7	Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	NCOA (HEDIS)	Yes 1516	Claims	APCD	The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	Yes	Yes	Yes	Yes	

Why a Common Measure Set?

- Legislative mandate
- To standardize the way we measure performance
- Promote voluntary alignment of measures
- Publicly share results on an annual basis through APCD

Additional Purposes of the Measure Set: Making the Data Actionable

- Leverage role as largest purchaser of healthcare in state
 - Use measures in contracts to drive payment and deliver system reform
- A path to performance-based payment arrangements
 - “North star” for how we select incentive-based measures
- Ensure equal access to high-quality health care
 - Identification of opportunities to improve value of health care provided through delivery systems



Development of Common Measure Set Successes

- Stakeholder driven process
 - Governor-appointed Performance Measures Coordinating Committee
- Convening partner – state accountable for measure set
- Standard set of measure selection criteria
- Multi-workgroup approach, depending on topic
- Full transparency is very important!
 - Allowing for public input at all times, as well as a formal public comment period

Development of Common Measure Set Challenges

- Keeping the total number of measures reasonable
- Practicing providers were not actively engaged in conversation
- Lack of understanding of purpose of measures
- Ongoing engagement/defining scope for PMCC

Lessons Learned

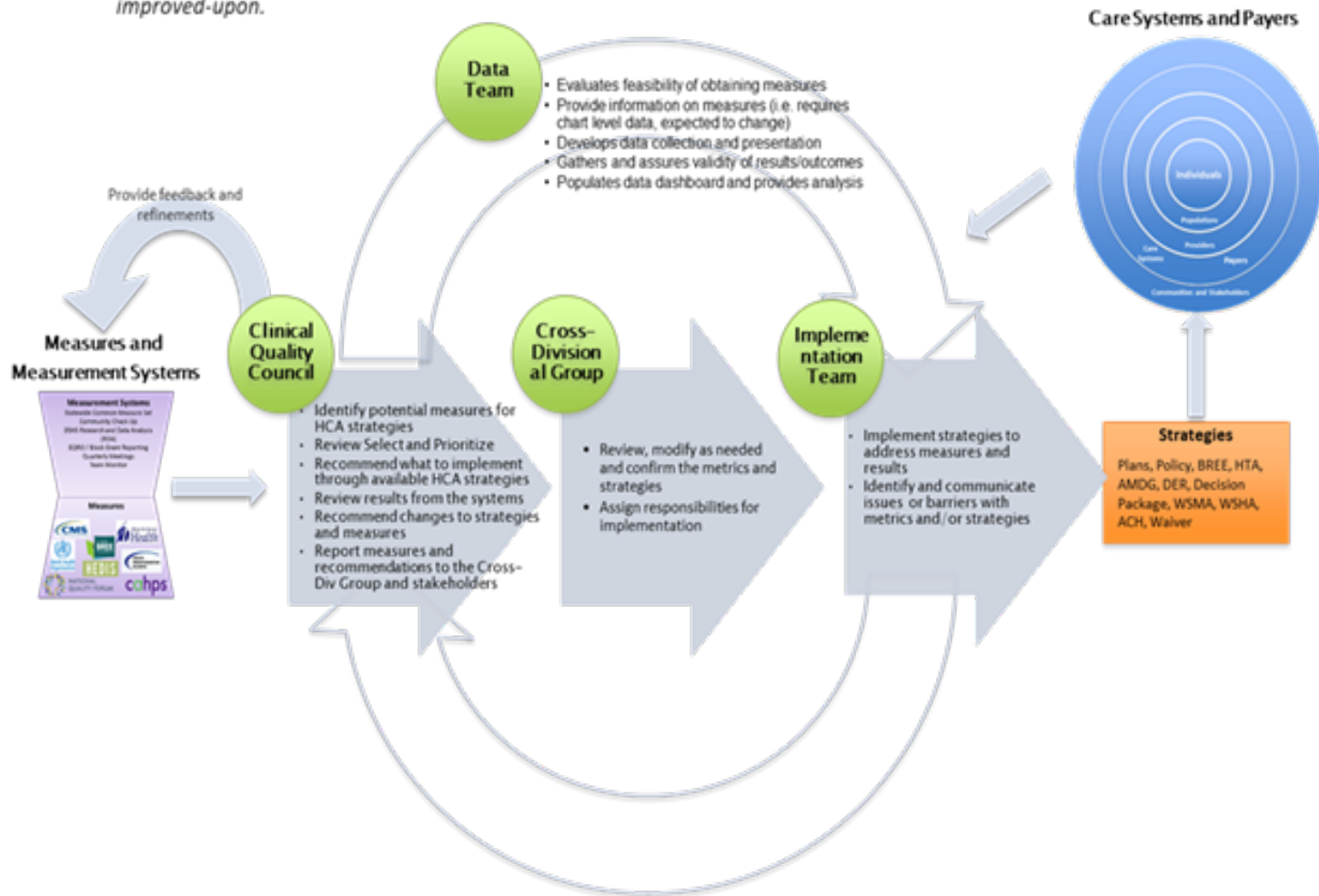
- Establish a clear goal and purpose statement from the beginning that is relevant to all potential end users
- Build in a strong communication and outreach strategy
- Find potential “critics” and engage them regularly
- Engage practicing providers in the discussion from the beginning
- Communicate, communicate, communicate!

Sustaining the Common Measure Set

- Plan for ongoing evolution of common measure set
- Work with commercial payers to ensure voluntary alignment, particularly with the VBP measures
- How do we continue to ensure we are using the right measures to drive quality?
 - Quality Measurement & Monitoring Improvement (QMMI)

Quality Measurement & Monitoring Improvement (QMMI)

The Quality Measuring, Monitoring and Improving (QMMI) process ensures that the right quality measures are selected and prioritized, statewide actions and implementation activities are coordinated, and measures are continually refined and improved-upon.



Alignment of common measures across performance-based contracts

Alignment of Common Measures Across HCAs Value-Based Payment (VBP) Contracts

“6” measures are common to all HCA’s VBP contracts:

“6” measures are common, or included in all HCA’s VBP contracts:

1. Antidepressant Medication Management - Effective Acute Treatment
2. Antidepressant Medication Management - Continuous Phase Treatment
3. Childhood Immunization Status
4. Comprehensive Diabetes Care: Blood Pressure Control
5. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
6. Controlling High Blood Pressure

Medicaid Managed Care & FQHC Pilot Contracts

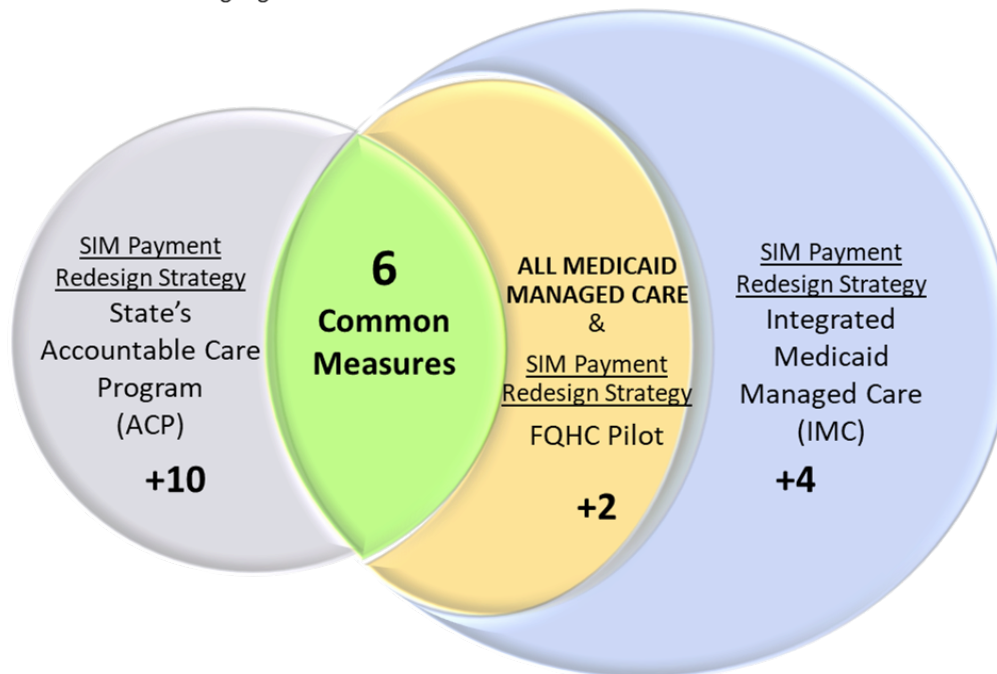
Have “8” quality measures tied to VBP. The 6 common measures plus the 2 below:

7. Medication Management for People with Asthma: Medication Compliance 75% (Ages 5-18)
8. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

IMC Contracts

Have “12” quality measures tied to VBP. The 6 common measures plus the 2 listed above for Medicaid Managed Care plus the 4 below:

9. Alcohol and Drug Treatment (Service) Penetration
10. Substance Use Disorder Initiation
11. Substance Use Disorder Engagement
12. Mental Health Treatment (Service) Penetration



ACP Contracts

Have “16” quality measures tied to VBP. The 6 common measures plus the 10 below:

7. Comprehensive Diabetes Care: eye exam
8. CVD Statin Prescribed
9. CVD Statin Adherence
10. Adult BMI Measurement
11. Cervical Cancer Screening
12. Chlamydia Screening
13. Breast Cancer Screening
14. Colorectal Cancer Screening
15. NTSV C-Section
16. Member satisfaction with (4 items):
 - A. Timely Care (always)
 - B. Provider Communication (always)
 - C. Office Staff (always)
 - D. Overall Provider Rating (9/10)

Source: UW SIM Evaluation Final Report, Jan 2019.

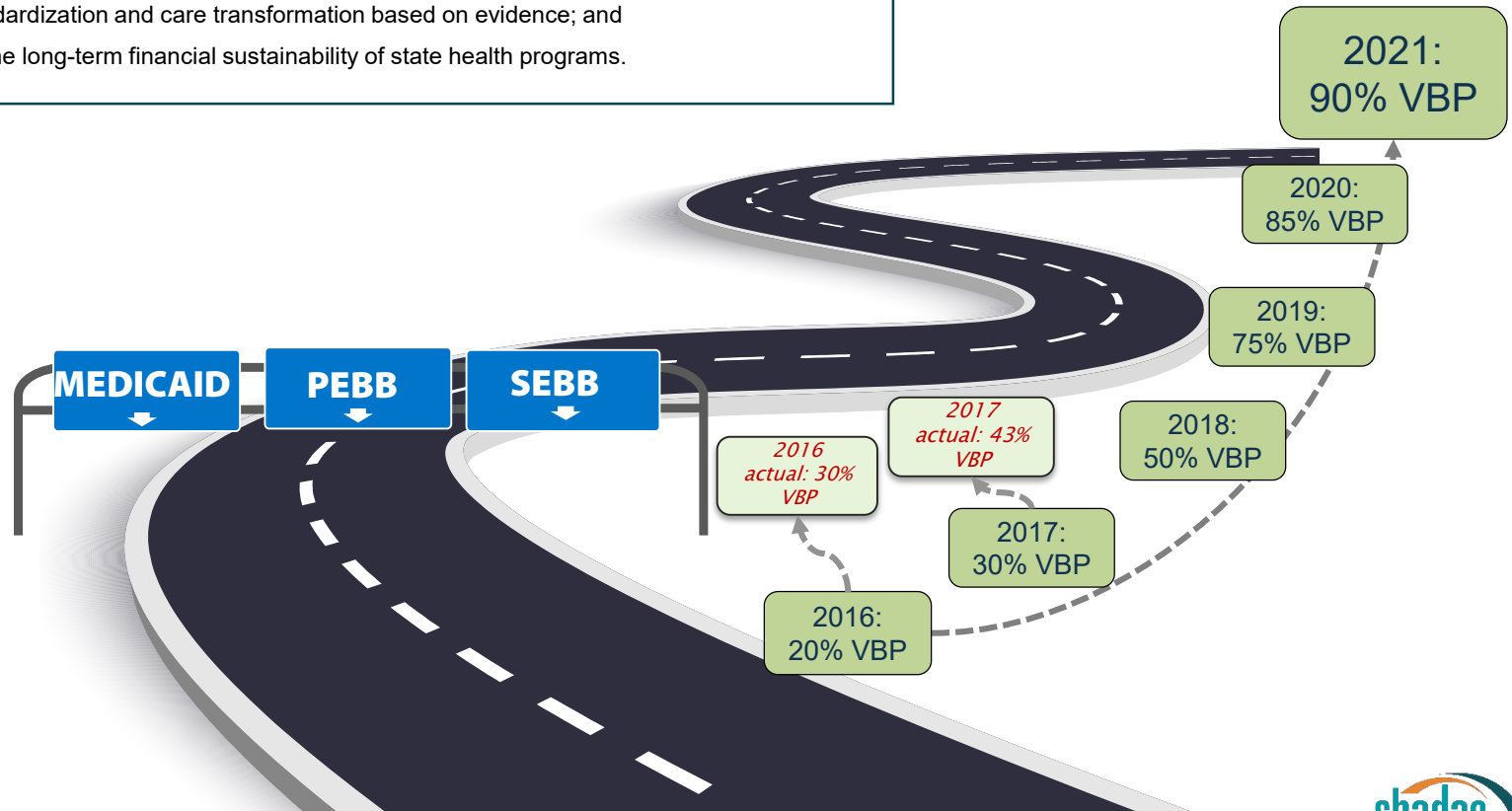
HCA's Value-based Purchasing Strategy

Advancing a “One-HCA” purchasing philosophy across Medicaid and employee benefits

Value-based purchasing roadmap

HCA's VBP Guiding Principles:

- 1) Continually strive for the quadruple aim of lower costs, better outcomes, and better consumer and provider experience;
- 2) Reward the delivery of person and family-centered, high value care;
- 3) Reward improved performance of HCA's Medicaid, PEBB, and SEBB health plans and their contracted health systems;
- 4) Align payment and delivery reform approaches with other purchasers and payers, where feasible, for greatest impact and to simplify implementation for providers;
- 5) Drive standardization and care transformation based on evidence; and
- 6) Increase the long-term financial sustainability of state health programs.



VBP Accountability

- MCO contracts – 1.5% withhold (*Medicaid*)
- Regence TPA contract – VBP PG (*Public/School Employees*)
- SEBB fully-insured plans – VBP PG (*Public/School Employees*)
- MTP – VBP incentives (*Medicaid*)
- Alternative Payment Methodology 4 for FQHCs (*Medicaid*)
- Rural Multi-payer Model – global budget for CAHs and rural health systems (*One-HCA*)
- Annual health plan & provider surveys (*One-HCA*)

The Road Ahead

- Incentivizing primary care
- Clinical integration of physical and behavioral health care
- Accountability for total cost of care
- Addressing social determinants of health and substance use disorder
- Patient engagement and empowerment
- WA-All Payer Claims Database - Pricing data
- MCO Quality Focus Measures

Multipayer Quality Measure Alignment: Lessons from SIM Evaluations

Jennifer Lloyd, PhD, MS, MA

SIM Round 1 Evaluation Lead

Research and Rapid-Cycle Evaluation Group,

Center for Medicare & Medicaid Innovation

Greg Boyer, PhD, MHA

SIM Round 2 Evaluation Lead

Research and Rapid-Cycle Evaluation Group,

Center for Medicare & Medicaid Innovation

SIM Round 1

- Vermont was the most successful in creating quality measure alignment across Medicare, Medicaid, and commercial payers.
- However, of the 4 states that created Medicaid ACO models, pre-existing Medicare and commercial ACO penetration within those states heavily influenced the Medicaid ACO design, including which quality measures were selected.
- There are a number of barriers states encountered that may be the most useful to discuss for lessons learned.

SIM Round 1

- All states invested SIM resources in quality measurement and reporting, a large portion of which were used to support new payment models in which financial incentives were tied to quality.
 - Providers viewed the increased use of quality metrics as useful in principle, but overly burdensome as implemented.
 - Recognizing the added burden, all states changed their alignment strategy.
 - Making health care cost and quality transparent to the public continued in states that initiated public reporting prior to the SIM Initiative (ME, MN, OR) and began in other states during the SIM Initiative (MA).
 - Although some incentivized quality metrics demonstrated improvement as new models were implemented, this improvement was far from universal.

Other Considerations

- How does this fit with MACRA quality reporting requirements tied to payment for MIPS/AAPMs (Medicare alignment), the Medicare Shared Savings Program, and other CMMI models (CPC+)?
- What about the Medicaid Scorecard can be harnessed to see the overlapping common metric areas across states (as most commercial payers have business not just in one state)?
- Beyond stakeholder engagement, what did states harness (health IT infrastructure or state data analytic investments statewide/within models) to bring about better alignment?

SIM Round 2

Early Struggles:

- Multiple sources of EHRs and a lack of standardization across MCOs
- Diverse populations not necessarily represented in all measures sets.
 - For example, a measure set tailored for a commercial population may be inappropriate to use for a Medicaid population.
- Early concerns also centered around alignment with already-existing systems and their integration with newer measure sets

SIM Round 2

More Recently:

- At least some states took advantage of their roles as payers (Medicaid) and focused their energies first on aligning measures within Medicaid before engaging other payers
- Additionally, some states leveraged flexible solutions around reporting requirements or allowed partial alignment for payers to retain some of their own measures.
 - This flexibility included aligning with existing Medicare models.
- Still other states moved away from state-defined measures and adopted nationally recognized versions seen as critical for payer buy-in

SIM Round 2

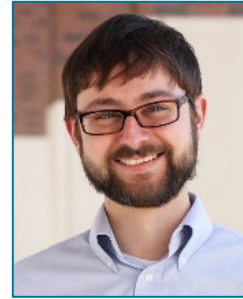
Most recently:

- States focused on establishing common measure sets and common definitions of measures.
- States have focused on overcoming barriers regarding noted concerns about actionable feedback including:
 - Provision of practice facilitators and clinical IT advisors
 - Soliciting specific provider feedback
 - Combining feedback reports across multiple payers into single reports.

Questions for Speakers?

CMMI

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- *J.D. Fischer*
Manager, Value-Based Purchasing, Washington Health Care Authority

Contact Information

Direct inquires to Colin Planalp, cplanalp@umn.edu
or shadac@umn.edu



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The SHADAC logo features the word "shadac" in a bold, teal, lowercase sans-serif font. Above the letters "a" and "d" is a thick, curved teal line that arches over the text. A thinner, orange curved line is positioned above the teal line, also arching over the text.

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STATE HEALTH ACCESS DATA ASSISTANCE CENTER