Aligning Quality Measures across Payers

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Introduction

With a growing emphasis on improving the quality of health care, public and private payers are increasingly measuring the performance of providers on a variety of quality metrics. The purpose of gathering these metrics is to evaluate health care providers and drive them to improve their performance, whether directly through pay-for-performance schemes that give providers financial incentives to improve or indirectly through transparency programs that allow health care consumers to compare the performance of providers and seek care from providers that deliver high-quality services.

The result of many payers individually selecting or developing their own quality measures has been a proliferation of many diverse measures. A related issue is that multiple payers may use the same or similar quality measures, but these individual payers may have different reporting requirements (e.g., time period for reporting). The large number of quality measures, with reporting requirements that may vary by payer, can create substantial administrative burden and make it difficult for providers to focus improvement efforts.

To help address these challenges, a number of states have undertaken efforts at aligning quality measures across multiple payers. In addition to the anticipated benefit of enhanced quality, these efforts at quality measure alignment could potentially yield other benefits. For example, if a system were devised for combining the quality measure data across multiple payers, the precision of the measures could be improved by increasing the size of population, and economies of scale could be achieved by reducing duplication in the reporting and analysis of quality measure data.

This paper describes the efforts of several of the SIM states and provides a framework for states interested in pursuing their own efforts at quality measure alignment, and Table 1 provides a comparison of the states' quality measure alignment efforts. Appendix A offers states a tool to catalogue existing quality measures and identify current alignment, and to consider how those measures meet states' goals and evaluation criteria.

Impetus and scope of measure alignment

Among the five states examined in this paper (Maine, Massachusetts, Minnesota, Oregon, and Vermont), efforts to align quality measures across multiple payers have stemmed from two sources: state legislation mandating the development of a standardized set of quality measures, or from states' SIM projects.[1] While the states followed similar processes for developing sets of aligned quality measures, the specific origins of states' efforts are important because they define the scope of their work.

Legislative origins

Three of the five states we examined began their alignment efforts as the result of legislation. The legislation in two of these states, Massachusetts and Minnesota, directed relatively broad efforts compared to the other states we examined. Minnesota's 2008 law directed the state health department to develop a standard set of quality measures and to publicly report on a subset of these measures, and it prohibited health plans from requiring health care providers to report on additional measures.[2] Massachusetts' 2010 law directs the state's Center for Health Information and Analysis to develop a standard set of quality measures, requires uniform reporting of the measures by providers, and requires that when health plans use quality measures to tier providers in small and non-group markets, they must select those quality measures from the standardized set.[3] Oregon's 2013 law was narrower in scope, establishing a work group to make recommendations for a set of common quality measures to be used by the state's health insurance marketplace, the Oregon Health Authority, and the state's teacher and public employee benefit boards.[4]

State Innovation Model origins

Maine and Vermont have efforts to develop standard quality measures that originated from their SIM projects. Rather than being broadly focused on all health plans or all providers like Minnesota or Massachusetts, these states' efforts are focused on SIM payment and delivery system reforms.[5,6]

Process of aligning quality measures

While states' initial reasons for undertaking quality measure alignment varied, as has the scope of their efforts, states have followed similar processes for establishing standard measure sets:

Developing stakeholder work groups

Each of the five states we examined established a work group of stakeholders to make recommendations for a standardized measure set. These groups typically included representatives of health care providers and facilities, health plans, consumers, technical experts in health care quality/research, and state agencies. The groups also included representatives of employers, though the types of employers reflect the focuses of the alignment efforts. For example, Minnesota, Massachusetts and Oregon's work groups include representatives from private employers, while Maine's work group includes representatives from public employers, and Vermont's work group did not have employer representation.

Identifying goals

In some cases, the goals of the alignment efforts were established in legislation creating the work group, as in Minnesota; by a committee that convened the work group, as in Maine; or by the work group itself, as in Oregon.

The goals of individual states' alignment efforts also reflect the reasons for their efforts. For example, the goals of Maine's alignment efforts were tailored to supporting the state's SIM objectives of strengthening primary care, improving transparency and understanding of health care cost and quality, and developing an aligned approach to payment reform. The goals of Minnesota's alignment work, which predates SIM, include making quality information more broadly available and limiting the administrative burden on health care providers.

Establishing criteria for evaluating measures

For each state, the measure alignment work groups established criteria for evaluating potential quality metrics. While there is substantial overlap in the criteria that work groups adopted to evaluate measures, individual work groups also adopted criteria unique to their specific goals. For example, Minnesota considered whether consumers would be interested in a measure, fitting with its goal of public transparency. Vermont considered whether a measure was representative of services provided and beneficiaries served by ACOs, a criteria matching the SIM program's aims of payment and delivery system reforms.

Common criteria for evaluating measures

Many of the criteria states used to in selecting measures were similar, with criteria to:

- Evaluate and compare measures (e.g., reliability and validity, and opportunity for improvement)
- Identify existing alignment (e.g., alignment across multiple health plans/payers, and applicability to most health care providers/facilities)
- Assess the practicality of the measures (e.g. whether data are readily available, and whether they would be burdensome to implement).

Table 1 compares evaluation criteria across states.

Compiling inventories of measures for consideration

In addition to adopting criteria for evaluating proposed quality measures, alignment work groups also developed inventories of quality measures for consideration. These inventories typically were composed of nationally recognized measures for consideration, (e.g., National Quality Forum-endorsed measures), measures currently being used by stakeholders (e.g., health plans), or a combination. For example, Oregon's work group limited its list of considered measures to those already being used by the entities for which it was making recommendations, while Massachusetts focused on a list of primarily nationally recognized measures that were mandated by legislation for inclusion in the measure set. States' work

groups used these inventories both for developing a list of measures for consideration, as well as for identifying overlap among the numerous measure sets.

Making recommendations for standard quality measure sets

After evaluating quality measures up for consideration, the states' work groups made recommendations for metrics to be included in an aligned measure set. There are several components to the work groups' recommendations:

Rankings versus endorsements

States' work groups followed two methods for making recommendations. Some, such as Oregon, followed a simple endorsement approach, in which the work group provided its recommendations for measures that should be included in the standard measure set. In their formal recommendations, these work groups typically provided a rationale, describing whether or how they met the evaluation criteria. Other states followed a ranking approach. For example, because its legislation requiring creation of a standard quality measure set mandated certain measures be included (e.g., Centers for Medicare & Medicaid Services process measures, Hospital Consumer Assessment of Healthcare Providers and Systems measures, and Healthcare Effectiveness Data and Information Set measures), Massachusetts' work group evaluated on a numerical scale how well each mandated and other non-mandated measures met evaluation criteria.

Current and future recommendations

Recognizing that some measures required further study or that data were not readily available to implement certain desired measures, some states provided two tiers of measures. The first tier was for measures they recommended for current implementation, and the second tier was for measures they recommended further examining in the future.

Recommendation to authorized entity

A common theme across the states was that each convened a work group of stakeholders to provide recommendations to another entity to make a final determination about the standard measure set. However, the entity with the responsibility for approving the final measure set varied among the states. In Maine and Vermont, the work groups were tasked to provide their recommendations to the states' SIM programs for consideration. In Maine, the state also will nominate these recommended measures to the Maine Health Management Coalition's Pathways to Excellence initiative, a voluntary program for public reporting on aligned quality measures.[1] In Massachusetts and Minnesota, whose efforts preceded SIM, the work groups provided their recommendations to state health agencies, which were given the authority to

make a final decision.[7,8] In Oregon, the work group provided its recommendations in a final report to the state legislature.[9]

Ongoing maintenance of quality measure sets

Most of the states developed methods for continuous or annual re-evaluation of their aligned measure sets. These involve review by the states' alignment work groups to consider whether to retire or modify existing measures, or add new measures. The re-evaluation processes are similar to the work groups' original processes of selecting aligned measures, although work groups sometimes made process revisions. For example, Massachusetts' work group changed its measure evaluation criteria for 2013, expanding the criteria from an original set of validity and practicality to also include reliability and validity, ease of measurement, existing field implementation, and susceptibility to improvement.

Use of aligned quality measure sets

Compared to the processes of aligning measure sets, which were similar across the five states, the states' intended uses of the standardized metrics were more highly varied. As mentioned earlier, they differed both in whom they were designed to be used by, as well as how they were to be used:

Who uses the measure sets

The scope of whom states intended to use the measure sets ranged from relatively narrow to very broad:

- Oregon's efforts at alignment focused on four state entities: The Oregon Health Authority, the state's health insurance marketplace, and the state public employee and teacher's benefit boards.
- Maine and Vermont's quality measure alignment work focused on developing standard sets of quality measures for use in their SIM payment and delivery reform projects.
- Minnesota and Massachusetts' measure sets were created for use by the states and by commercial health plans.

How the measure sets are used

Some states have implemented their standardized quality measure sets, while others have not yet formally adopted their measures. Additionally, they took different approaches to how the measures were intended to be used:

- Oregon's work group provided recommendations of how the four entities under its focus could use the measures. For example, it suggested the Oregon Health Authority

could use them for public reporting and payment for the state's Coordinated Care Organizations.

- Maine and Vermont undertook quality measurement alignment with the intentions of publicly reporting and using the data for performance-based payment, as well as monitoring their SIM programs.
- The legislation that produced Massachusetts and Minnesota's efforts included instructions for how the measure sets were to be used:
    - Minnesota prohibited health plans from requiring that health care providers report quality measures other than those in its Statewide Quality Reporting and Measurement System. The state's measure sets also were designed for public reporting and are used in a statewide Quality Incentive Payment System (QIPS).
    - Massachusetts required providers to report on its Standard Quality Measure Set, and it required that when health plans use quality measures for developing provider tiers in small group and non-group, they must select those measures from the aligned measure set. The measures also were designed for public reporting.

Table 1: Comparison of State Quality Measure Alignment Efforts

	Minnesota	Oregon	Vermont	Maine	Massachusetts
Impetus for alignment effort	Legislatively mandated	Legislatively mandated	To support SIM objectives	To support SIM objectives	Legislatively mandated
Stakeholders included	• Health care providers and facilities • Health plans • Employers and other purchasers • Consumers • Technical experts	• Health care providers and facilities • Health plans • Employers • Consumers • Technical experts • Plus OHA, exchange, PEBB and OEBB	• Health care providers and facilities • Health plans • Consumers • Technical experts • IT expert • Green Mountain Care Board • Numerous state agencies	• Health care providers and facilities • Health plans (including Medicaid) • Public employers	• Health care providers and facilities • Employers • Health plans • Consumers • Public employee benefits commission • Center for Health Information and Analysis • Medicaid • Multiple state agencies
Goals of alignment efforts	• Public reporting • Reduce administrative burden on health care providers • Payment incentives	**Triple Aim:** 1. Improved care 2. Improved health 3. Reduced costs	**Triple Aim:** 1. Improved care 2. Improved health 3. Reduced costs	**Support SIM project objectives:** • Strengthening primary care • Public reporting • Payment reform	• Improve health care quality • Reduce costs • Public reporting
Main criteria for evaluation of measures					
Reliable and valid	✓	✓	✓	✓	✓
Readily available/ feasible to implement		✓		✓	✓

	Minnesota	Oregon	Vermont	Maine	Massachusetts
Importance/relevance	✓			✓	
Not administratively burdensome			✓	✓	
Opportunity for improvement	✓		✓	✓	
Inclusive of most or all providers/ hospitals	✓	✓			✓
Outcomes focus	✓	✓	✓		✓
Aligned with other measure set(s)	✓	✓	✓	✓	✓
Measures progress toward policy objectives			✓	✓	
Use of measures					
Who?	• Public and private payers limited to using standard measures • All providers required to report a subset of the standardized measures	• State purchasers • Health insurance exchange	• ACOs • Vermont SIM	• MaineCare and commercial health plans agree to use the aligned measures through adoption by the voluntary Pathways to Excellence initiative	• Payers limited to using standard measures when using quality to tier networks • Required reporting by health care facilities, medical groups and provider groups
How? (e.g., reporting, payment)	Reporting and payment	Reporting (quality ratings for QHPs) and purchasing decisions by public payers	Reporting and payment	Reporting and payment	Reporting and tiering of networks by health plans
Updating measures	Annual review		Annual review		Annual review

Additional Resources:

- The Buying Value program offers a tool for developing measure sets: http://www.buyingvalue.org/resources/toolkit/.

[1] The Pathways to Excellence initiative is a voluntary program in Maine that has developed a standard set of quality measures, which are reported publicly. The initiative is a project of the Maine Health Management Coalition, a group of public and private payers, health plans, hospitals, and providers. While the Pathways to Excellence program has existed for approximately a decade, this paper focuses instead on Maine's SIM efforts to align quality measures due to greater availability of public information about its process.
[2] Minn. Stat. § 62U.02 (2008).
[3] An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses. 2010 Mass. Acts 288.
[4] An Act Relating to Qualified Health Plans Offered Through the Oregon Health Insurance Exchange; and declaring an emergency. Or. H.B. 2118 (2013).
[5] Vermont Health Care Innovation Project Quality and Performance Measures Work Group Charter. (2014). Available at: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/QPM_Draft_Charter_v5_2014-01-07_CLEAN.pdf.
[6] ACI Measure Alignment Work Group (Maine) Meeting Notes. 2014, April 3. Available at: http://www.mehmc.org/download/wok-group-meeting-notes-april-3-docx/.
[7] The recommendations of Massachusetts' work group are available at: http://chiamass.gov/sqac/.
[8] The recommendations of Minnesota's work group are available at: http://www.health.state.mn.us/healthreform/measurement/pastrecs.html, and http://www.health.state.mn.us/healthreform/measurement/recommendations.html.
[9] The work group's final report to Oregon's legislature is available at: http://library.state.or.us/repository/2014/201406021322111/.