



Aligning Quality Measures across Payers: Lessons from State Innovation Models

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EXECUTIVE SUMMARY

In an effort to support transitions to value-based payment for health care, some states are working to align the measures that commercial and public payers use to evaluate quality. These quality measure alignment initiatives are typically aimed at reducing measurement burden on providers and enhancing quality by emphasizing performance on a common set of quality measures used by multiple payers. By drawing on the experiences of several states from the Center for Medicare & Medicaid Innovation's State Innovation Models initiative, this issue brief provides a framework for other states undertaking their own quality measure alignment projects.

Determining a Strategy

States adopted two broad strategies for quality measure alignment: 1) mandating that commercial payers align across a set of common measures, or 2) encouraging commercial payers to align voluntarily with a common measure set. The decision whether to adopt a mandatory or voluntary alignment strategy influences states' future decisions around developing and implementing a common measure set. In deciding on a strategy, states considered the availability, feasibility, and strength of levers available to them, such as using contracts to require alignment by Medicaid managed care organizations or using regulatory authority to require that plans offered in state health insurance marketplaces align with set of common measures. Other facilitators such as existing environment or forums for collaboration among stakeholders are also factors.

Articulating Rationale

Under a voluntary strategy, articulating a rationale or setting goals for alignment can play a key part in persuading payers to adopt a common measure set. Under a mandatory strategy,

articulating a rationale can also help maximize alignment by encouraging payers to agree to common measures beyond what is minimally required.

Determining Scope

To plan to implement a common measure set, states must determine the scope of their alignment efforts, including: 1) which policy levers to use for mandating or encouraging voluntary alignment, 2) whether and how public payers—in addition to commercial payers—should use the common measure set, and 3) what other existing or new programs could and should use the common measure set.

Engaging a Workgroup

All SIM states with alignment efforts used stakeholder workgroups to develop their common measure sets. By engaging a range of stakeholders (e.g., commercial and public payers, health care providers, consumers), workgroups can develop buy-in among important groups and gather input to ensure the common measure sets are feasible and meet stakeholders' priorities.

Identifying Measure Selection Criteria

The identification of criteria to systematically evaluate measures under consideration was a foundational component of states' alignment workgroups. Use of these criteria helped ensure stakeholder's confidence in the common measure set.

Inventorying and Evaluating Measures

After identifying measure selection criteria, some workgroups developed inventories of measures for consideration, which typically included measures used by payers in the state and other vetted measure sets (e.g., National Quality Forum [NQF]-endorsed and Healthcare Effectiveness Data and Information

Set [HEDIS] measures). Workgroups, then, evaluate measures in their inventories according to their measure selection criteria.

Selecting Measures

The final major step in developing a common measure set is to determine which measures to include in the set, as well as how to structure it. States' workgroups consider their evaluation of measures according to selection criteria, including how heavily certain criteria are weighted, and other measurement priorities and goals (e.g., high-priority health conditions such as diabetes or goals such as supporting quality transparency). States also typically organize their common measure sets into subsets, such as "core" measures for mandated use and "menu" sets of optional additional measures.

What is a Common Measure Set?

A common measure set (or aligned measure set) is a shared set of measures developed for use by multiple payers, either in its entirety or as a "menu" from which payers may select, with the purpose of reducing measurement variation.

Sustaining Alignment

Because performance and measurement priorities change over time, states should also develop plans for maintaining their measure sets, such as a plan for retiring measures where providers have improved and "topped out" performance as well as a method for adding measures as new quality priorities emerge.

INTRODUCTION

As payers increasingly shift from fee-for-service to reimbursement models that reward health care providers for controlling costs and ensuring quality, the number and diversity of measures used to assess the quality of care that providers deliver have proliferated. However, by setting priorities and selecting quality measures independently and without coordination, payers' efforts to encourage quality improvement may not have their intended effects.¹

Counterintuitively, too many quality measures may result in a reduced focus on quality improvement and possibly even lower quality. For example, by requiring providers to report, track, and manage their performance on many different measures for different payers, the additional administrative burden may reduce the amount of time providers can spend treating patients. In addition, the growing number of measures may dilute providers' improvement efforts by distributing focus across too many measures, resulting in little or no gains in performance, or it may cause providers to triage quality improvement efforts in ways that do not reflect payers' priorities.^{2,3,4,5}

Recognizing potential benefits to multiple stakeholders—including payers, providers, and consumers—some states

developed common measure sets designed to be used by multiple payers to align quality measures. Many of the states that are leading quality measure alignment efforts received State Innovation Model (SIM) initiative awards from the Center for Medicare and Medicaid Innovation (CMMI). SIM states have undertaken multipayer approaches to transforming health care payment and delivery systems to achieve improved quality of health care, reduced health care costs, and improved population health.

By drawing on the experiences of a group of selected SIM states, this issue brief outlines a framework for how other states may align quality measures across multiple payers for health care services.

ALIGNING QUALITY MEASURES

This framework draws primarily from the experiences of five SIM states actively engaged in work to align quality measures to support a shift to value-based payment: Connecticut, Massachusetts, Minnesota, Rhode Island, and Washington. Despite some important differences in how these states approached quality measure alignment, all offer strategies and lessons for other states embarking on measure alignment.

Determining a Multipayer Strategy

Determining their approach for achieving quality measure alignment across payers is an important strategic decision for states. States already have the ability to affect adoption of common measure sets for their own public payers (e.g., Medicaid, public employee benefits, etc.), so the strategic decision rests largely on how states will push commercial payers to align quality measures. SIM states are using two main strategies with their commercial payers: voluntary alignment, which relies on various approaches to persuading payers to use a common measure set, and mandatory alignment, which may require payers to use a common measure set or prohibit them from using measures other than those in a common measure set.

Voluntary Alignment

Under a voluntary alignment strategy, commercial payers are encouraged to adopt measures from a common measure set and to limit their use of other measures but are not required to do so. Two SIM states—Connecticut and Washington—adopted a voluntary approach. To encourage commercial payer buy-in, they made stakeholder engagement a cornerstone of their alignment strategies. This involved engaging commercial payers throughout the stakeholder process to ensure the common measure sets met their needs and priorities.

Voluntary or Mandatory Alignment

Within the main strategies for achieving alignment across payers—particularly commercial insurers—states have taken varied approaches:

Voluntary alignment

Some states have chosen not to mandate that commercial payers align quality measures and instead employ various tools to encourage payers to align voluntarily, such as stakeholder engagement.

Mandatory alignment

States that have mandated measure alignment among commercial payers have used one of two approaches (or both):

- 1) Requiring use of common measures. States have required that commercial payers use all or some of the measures in a common measure set.
- 2) Prohibiting use of other measures. States have prohibited commercial payers from using measures that aren't included in a common measure set.

States have found that leveraging existing stakeholder efforts can be an effective way to build momentum toward alignment. For example, Washington worked with a nonprofit organization that operated the state's voluntary all-payer claims database and quality transparency website. The state was able to tap into a collaborative effort already in place that included the relevant stakeholders whose buy-in and participation in developing the common measure set was critical.

Even when adopting a voluntary approach to measure alignment, certain policy levers may be useful to jump-start and promote the effort. Washington's legislature, which authorized the Statewide Common Measure Set, also required that state purchasing of health care (e.g., public employee health plan, Medicaid managed care) use measures from the aligned measure set in the state's shift to value-based payment.⁶ In Connecticut, the state has developed a public scorecard website to promote its Multi-Payer Quality Measure Set through quality transparency, encouraging payers to use those measures by highlighting them for providers and consumers.

Mandatory Alignment

SIM states using a mandatory strategy for quality measure alignment have either required commercial payers to adopt quality measures from common measure sets (a positive mandate), prohibited them from using measures not included in common measure sets (a negative mandate), or used a combination of both approaches.

Massachusetts and Rhode Island offer examples of requiring all commercial payers in the states to use measures from common measure sets, at least under certain circumstances. In Massachusetts, payers are required to use measures from the state's Standard Quality Measure Set (SQMS) in any plans that tier provider networks based on quality.⁷ The

Massachusetts legislature distributed responsibility for the common measure set across multiple agencies, with the Department of Public Health convening the stakeholder group that recommends measures, the Center for Health Information and Analysis (CHIA) making final determinations on which measures to include, and the Division of Insurance overseeing commercial insurers' use of the measure set for tiering. In Rhode Island, regulations promulgated by the Office of the Health Insurance Commissioner require commercial payers to use measures from the state's Aligned Measure Sets in any payment contracts with providers that include quality measures.⁸

Instead of requiring commercial payers to use specific measures, the Minnesota legislature prohibited payers from requiring providers to use or report on quality measures that aren't included in the Statewide Quality Reporting and Measurement System (SQRMS).⁹ In some cases, states also have reinforced their mandate strategies with additional steps that may further encourage voluntary alignment. For example, statutes in both Minnesota and Massachusetts require providers to report measures in their common measure sets for public reporting and transparency efforts, signaling to payers that providers are already focused on those measure sets.

In addition to differences in how states mandate payers to align with common measure sets, there are differences among SIM states in the authorities they use to set those mandates.

Lessons Learned

Successful measure alignment depends on engagement of key stakeholders, such as commercial payers and health care providers, to ensure buy-in and usefulness of a set of core measures. Stakeholder engagement is vital to obtaining voluntary alignment, but even states with alignment mandates have emphasized the role of stakeholders. Some states have used existing stakeholder forums to garner support and participation in the effort.

Articulating a Rationale

By aligning with a common set of quality measures, payers forgo some autonomy to use their own preferred measures in return for potential benefits of a collective focus by payers and providers on a narrower set of measures. To make the case to stakeholders, one of the foundational steps taken by SIM states has been to identify and articulate the specific goals they want to achieve with alignment.

When and How

States have taken different approaches to when and in how much detail to lay out the goals of alignment. In some cases, states have articulated their foundational rationale before even beginning the stakeholder workgroup process to develop a common measure set. For example, the statute authorizing Minnesota's common measure set established a goal that it shouldn't increase administrative burden on providers and that it promote quality transparency through public reporting. In

other cases, the stakeholder workgroups that develop common measure sets also establish their goals. For example, Connecticut's Quality Council workgroup set a guiding principle that the measure set should "assess the impact of race, ethnicity, language, economic status, and other important demographic and cultural characteristics important to health equity."¹⁰

Common Alignment Rationale

In setting their goals or principles for common measure sets, some themes were shared across all or most states:

- Encouraging a transition to value-based payment
- Containing or reducing provider measurement burden
- Promoting transparency of health care quality

While establishing a rationale for quality measure alignment can be particularly important for engaging payers under a strategy of voluntary alignment, it can also play an important role in helping to engage payers under a mandatory alignment strategy. In a state such as Minnesota that prohibits payers from using measures outside the statewide common measure set, payers still have the option not to include quality measures in payment arrangements with providers if they don't see value in using measures from the common measure set. States are more likely to experience meaningful alignment if a broad range of stakeholders have "bought in" to the value of the aligning measures and choose to go beyond any narrow applications of requirements to align.

Lessons Learned

When and how states articulate a rationale for measure alignment can serve different purposes. In states that set out their rationale for alignment before convening a stakeholder group, such as through legislation, the rationale can be a tool for bringing stakeholders to the table. In states that develop a rationale with input from their stakeholder groups, the process can help to develop buy-in and ensure priorities consider those of key groups.

Determining Scope of Measure Set

In addition to selecting a strategy (i.e., voluntary or mandatory) and articulating a rationale for measure alignment, SIM states also had to determine the scope of their measure alignment efforts—questions of which payers and programs should use a common measure set and which policy levers should be used to promote the measure set.

Use of Policy Levers

As described earlier, some states have used relatively broad statutory or regulatory authorities to mandate commercial payers' alignment with a common measure set, such as by prohibiting payers from using measures other than those in the common measure set or by requiring payers to use the common measure set in value-based reimbursement contracts. Particularly when determining voluntary alignment strategies,

states should consider which more-targeted policy levers they have available to persuade commercial payers to use their common sets, as well as whether and how to use those levers.

Regulatory Levers

In contrast with use of broad regulatory authority, states have considered more targeted use of regulation to encourage alignment. For example, some states have weighed using insurance regulations to require that individual and small-group market plans sold through state health insurance marketplaces use common measure sets.

Contracting Levers

States may consider using contracts with commercial payers as a lever for driving adoption of common measure sets for public programs, such as requiring alignment via contracts with Medicaid managed care organizations or with payers acting as third-party administrators for public employee health benefit plans. For example, Connecticut uses its common measure sets in contracting for public employee health benefits, and Washington uses its measure set in its Medicaid plans and public employee health benefits. Alternatively, states could adopt the measures themselves if they don't contract with commercial health plans.

Adoption in New or Existing Initiatives

Another consideration for states is how their common measure sets could be used in existing or new programs, both to promote the measure sets themselves and to dovetail with other policy goals, such as incorporating value-based payment reforms into public health care programs, furthering public transparency efforts about health care quality and tying quality measurement efforts to broader public health initiatives. For example, Minnesota uses its SQRMS measures in its Health Care Homes program, a multipayer patient-centered medical home initiative, as well as in the Quality Incentive Payment System, a pay-for-performance program for public employees and Medicaid beneficiaries. Multiple SIM states are using their common measure sets in public reporting efforts, such as with websites that publish quality data on health care providers. And Rhode Island and Washington also have included measures of appropriate opioid prescribing in their common measure sets to reinforce other initiatives to intervene in the national opioid overdose death crisis.

Lessons Learned

To jump-start adoption of common measure sets by commercial payers, states frequently also adopt the measure sets in programs under their control. For example, by adopting common measure sets in a Medicaid value-based payment arrangement with health care providers, states can give those measures a foothold.

Engaging a Workgroup

The SIM states highlighted in this brief each convened stakeholder workgroups as part of their processes to develop

common measure sets. Each of the workgroups included representatives from a range of key stakeholder groups (e.g., payers, providers, consumers), which was essential for bringing diverse expertise and interests to the development of a common measure set.

The stakeholder-driven approach can provide an opportunity for identifying common priorities, such as a focus on quality of diabetes care. The workgroup process also can serve as a vehicle for obtaining input on whether specific measures are useful for furthering a state's goals for quality measure alignment. If a state wants to use its common measure set for a transparency effort to report provider quality performance on a public website for consumers, for example, then consumer groups could provide input on whether measures being considered are meaningful and understandable for consumers.

Workgroup Members

In their alignment efforts, states usually included several types of stakeholders:

- Commercial payers
- Public payers (e.g., Medicaid agencies, public employee benefits, etc.)
- State agencies (e.g., insurance departments, health departments, etc.)
- Health care providers (e.g., hospitals, physicians, etc.)
- Consumers (e.g., consumer advocacy organizations, individual consumers, etc.)
- Others (e.g., Native American tribes, labor unions, private employers/employer associations, quality measure experts, etc.)

A stakeholder process also may be used for developing buy-in and encouraging commercial payers to adopt a common measure set by considering the priorities of payers, such as ensuring measures are pertinent to their beneficiary populations and feasible for them to collect and implement. For example, if commercial payers see few claims for a particular health condition, quality measures for that condition may not be well suited to a common measure set. Similarly, the stakeholder process can help to ensure that provider communities have bought in to the selected measures. For example, providers may be more wary of measures that are heavily influenced by patient behavior rather than providers' compliance with evidence-based care (e.g., HbA1c testing versus HbA1c control among diabetic patients).

In some cases where measure alignment was authorized through legislation, such as Massachusetts and Washington, that legislation also identified specific stakeholder groups that should be included in the development of a measure set. However, the types of stakeholders included in measure alignment workgroups were broadly similar regardless of whether they were prescribed in legislation or determined otherwise.

States have taken different approaches to how they facilitate the stakeholder process of developing a common measure set. In some examples, such as Connecticut and Rhode Island, the staff from state agencies involved in SIM payment and delivery system transformation initiatives have facilitated the workgroup processes. In other cases, states have worked with existing entities with experience working with stakeholders on issues related to quality measurement to serve as a neutral third-party convener, such as Minnesota Community Measurement and the Washington Health Alliance. Additionally, some states have hired consultants to provide technical assistance to workgroups, such as to compile information about measures or to help create measure inventories.

Lessons Learned

States consistently include commercial payers, public payers, and health care providers in their stakeholder workgroups because their input is important for building a meaningful and practical measure set and for encouraging its adoption. Bringing in other stakeholders can serve more specific purposes, such as including large employers as part of a strategy to persuade self-insured employers to voluntarily align with common measure sets in self-insured plans.

Identifying Measure Selection Criteria

After convening a workgroup, among the first steps in states' development of a common measure set is to identify a set of measure selection criteria. Those criteria are used to ensure that any measures under consideration are systematically evaluated according to predetermined standards and to prevent arbitrary decisions that could undermine stakeholders' confidence in the measure set.

In some cases, the legislation authorizing states' quality measure alignment efforts had set some measure selection criteria, such as in Minnesota and Washington. However, even when legislation prescribed certain measure selection criteria, workgroups also typically identified their own additional criteria.

Picking the Right Measures

Across state alignment efforts, many measure selection criteria overlap, and they fit within a few domains:

- **Opportunity for improvement** (e.g., gap between actual and optimal performance, performance variation across providers, influence on individual and population health, ability to be influenced by providers)
- **Proven/consensus measures** (e.g., preference for NQF-endorsed or other consensus measures, evidence-based measures that are reliable and valid, ready availability of benchmarks, sufficient base rates for measurement)
- **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)

Some states also identified measure selection criteria to evaluate the extent to which measures meet other stated policy goals, such as promoting payment reform and a shift toward value-based payment and enhancing health equity and inclusivity.

Inventory and Evaluation of Measures

After identifying measure selection criteria, SIM states then created inventories of measures for consideration and evaluated those measures according to their selection criteria. In developing their measure inventories, states have typically compiled in a spreadsheet all of the quality measures currently used by payers in their state, as well as from other selected measure sets that are being considered. To facilitate their work, workgroups have organized their measure inventories by sorting and grouping measures into domains (e.g., diabetes measures, emergency department measures, etc.); see example in Figure 1. That sorting exercise becomes useful as workgroups make selections of measures for inclusion in their common measure sets.

Figure 1: Sample Quality Measure Inventory

Measure	Payer 1	Payer 2	Payer 3	Existing 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

Once workgroups have created inventories of measures, they may begin to evaluate the measures according to their measure selection criteria. Members of the workgroup typically perform this task, making judgements on how well the measures meet the criteria and then recording the decisions on a spreadsheet (see Figure 2).

Figure 2: Sample Measure Selection Criteria Evaluation

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	

Select Measures for Common Measure Set

The final major step in developing a common measure set is for workgroups to select measures for inclusion in those sets. In most cases, stakeholder workgroups make their measure set recommendations to a state agency that has authority to make final decisions, such as the Minnesota Department of Health, the Washington State Health Care Authority, and Rhode Island's Office of the Health Insurance Commissioner. The selection of measures for recommended measure sets involves consideration of numerous factors, including:

Weighing Selection Criteria

In making final selections of measures for a common measure set, all states have considered how individual measures were evaluated according to their selection criteria (described in the prior section). However, the ways the criteria are applied can vary. For example, some criteria may be weighed more heavily, with some states placing special emphasis on whether measures are endorsed by the NQF or are included in prominent national measure sets (e.g., HEDIS). In the case of Massachusetts, the legislation establishing the measure alignment effort required inclusion of measures from certain existing measure sets regardless of whether they met the workgroup's selection criteria, so although those measures were still evaluated on the selection criteria, they were included regardless of how they scored.

Measurement Priorities and Goals

During the workgroup process or elsewhere (e.g., legislation), states may have set priorities for measure domains (e.g., specific conditions, such as diabetes or substance use disorder) or goals (e.g., supporting quality transparency). For example, Connecticut made behavioral health and pediatric measures priorities by convening subgroups to examine measures within those domains. The state's workgroup also prioritized health equity, recommending that measures be stratified by race and ethnicity to identify health disparities. The legislation authorizing Minnesota's alignment effort identified preventive services, heart disease, diabetes, asthma, and

depression as priority measurement domains that were required to be included in the state's common measure set.

Subsets of Measures

Within their common measure sets, states often create measure subsets to be used for distinct purposes. Most commonly, states have created measure subsets for different types of providers. For example, Minnesota's SQRMS includes a physician clinic measure set and a hospital measure set. Depending on the unique strategies and aims of their efforts, states also have developed other types of subsets. Rhode Island created subsets of "core" measures that payers are required to adopt and optional "menu" measures from which payers may select in addition to the core measures. Connecticut also adopted a "core" set of measures that they recommend payers use in value-based payment arrangements and a "reporting" set of measures recommended for public reporting to further transparency goals.

Lessons Learned

In the process of selecting measures, workgroups often find that some measures address their priorities or offer future promise but don't yet warrant inclusion in the common measure set because they don't currently meet selection criteria. To address that, workgroups often create sets of "development" or "monitoring" measures, which serve dual purposes of establishing a working set of measures to be revisited in the future and signaling to providers and payers that those measures may become future priorities.

Sustainability of Measure Alignment

To prevent their common measure sets from becoming less effective over time, each of the states we examined has developed plans for refreshing the sets over time. This is important because measures may become outdated as providers improve their performance, as medical evidence changes, or as quality priorities evolve.

Massachusetts and Minnesota have the longest experience with their common measure sets, having begun their work during state health reform initiatives that preceded their SIM awards. Since the states developed their first common measure sets (Minnesota in 2009 and Massachusetts in 2012), their alignment workgroups have updated the states' measure set recommendations on an annual basis, including adding or removing measures that were added or removed from national measure sets.

Importance of Measure Set Maintenance

Without continual updates, a common measure set can become stale for numerous reasons:

- Providers may "top out" their performance, leaving little room for further improvement.
- Evidence may change, either related to the measure itself (e.g., reliability) or underpinning medical rationale (e.g., changing screening protocols).
- Feasibility of measures may change (e.g., allowing a shift from claims-based to clinical quality measures).
- Quality priorities may evolve (e.g., recent focus on appropriate opioid prescribing to address the overdose crisis).

Of the states that initiated their quality measure alignment under SIM, two states (Rhode Island and Washington) have made at least one round of updates to their common measure sets, and the third (Connecticut) also plans to continue its workgroup's alignment efforts through a measure set maintenance process similar to development of an initial common measure set. Both Rhode Island and Washington offer examples of states updating their common measure sets in response to evolving priorities. In these states, their workgroups added quality measures for appropriate prescribing of opioid painkillers as part of the states' broader responses to the national opioid overdose crisis and concerns about overprescribing of opioids.

Lessons Learned

While annual maintenance of common measure sets is usually designed to make marginal revisions—retiring and adding individual measures—some states with longer experience with measure alignment have found a need to also occasionally revisit the foundational aspects, such as reconsidering their rationale for alignment and setting new measurement priorities.

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