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(Carrie Au-Yeung): Hello everyone, and welcome to today's webinar, Supporting Payment and Delivery System Reform through Multipayer Quality Measure Alignment: Lessons from State Innovation Models. Thank you for attending. It's great to have all of you join us today.

My name is Carrie Au-Yeung, and I'm a Research Fellow here at the State Health Access Data Assistance Center, or SHADAC. I'll be facilitating today's webinar, which will be discussing multipayer quality measure alignment as a strategy for supporting healthcare payment, and delivery system reform.

Before we get started, we have a few technical items to cover. If you're not able to access the broadcast audio for today's event, all information for dialing in is provided on the current slide. And if you're having any difficulties with ReadyTalk, you can call 1-800-843-9166, or you can ask for help via the chat feature

The current slide also contains the link to the downloadable slide deck for today's event. Speakers will be responding to questions from the audience after all presentations are concluded. And we do encourage you to submit questions throughout today's webinar via the chat feature on the left hand side of the viewing screen.

Finally, today's webinar is being recorded, and we will notify you when it is posted on SHADAC's Web site.

As a quick introduction to our organization, SHADAC is a multi-disciplinary health policy research center, with a focus on state health policy. We're affiliated with the University of Minnesota School of Public Health. And 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. You can learn more about us at SHADAC.org.

SHADAC currently provides technical assistance to states that receive state innovation model -- or SIM -- awards from the Center for Medicare and Medicaid Services, to accelerate healthcare transformation. SHADAC provides this TA as part of a team led by NORC at the University of Chicago, that serves as the resources support contractor. In this role, SHADAC and other technical assistance counterparts support states and the Center for Medicare and Medicaid Innovation -- or CMMI -- and designing and testing multipayer health system transformation approaches.

We are excited that several speakers from partner organizations and states are joining us for today's webinar. From CMMI we have Jennifer Lloyd and Greg Boyer, leads for SIM Round 1 and Round 2 evaluations. They'll be presenting findings related to quality measure alignment from the federal SIM evaluations.

Here at SHADAC is Colin Planalp, a senior research fellow who will discuss a roadmap for undertaking multipayer quality measure alignment, drawing from an issue brief that examined the experiences of selected SIM states and their initiatives to develop common measure sets.

And finally, from Washington state we're joined by Bonnie Wennerstrom, Laura Pennington, and J.D. Fischer. Bonnie, the former SIM project director for Washington, and currently Healthier

Washington connector, will give a brief introduction to Washington's SIM initiative, and a role that quality measure alignment played in the state's plan.

Laura, a practiced transformation manager at the Washington State Health Care Authority, will discuss the state's experience developing a multipayer common measure set.

And J.D., who is the value-based purchasing manager for the Health Care Authority, will discuss how Washington's common measure set fits into the state's broader value-based purchasing strategy.

Here is a high-level overview of what we'll be covering today, with presentations drawing on experiences of states that receive State Innovation Model or SIM awards from the Center for Medicare and Medicaid Services, to accelerate healthcare transformation. Many of the SIM states have undertaken robust stakeholder-driven effort to align quality measures across both private and public payers, such as commercial insurers, Medicaid, and public employee health benefit plans.

Before we begin, just a quick reminder that there will be a Q&A session after the speakers present, and questions or comments addressed to any of the presenters may be submitted through the chat feature at any time. We will relay your questions to the appropriate respondent during the Q&A.

At this point, I will hand the call off to Colin Planalp from SHADAC.

Colin Planalp: Thank you (Carrie). Today I'll be presenting key findings from an issue brief that I wrote with support from CMMI about several SIM state experiences with multipayer quality measure alignment. The purpose of that paper and my presentation today is to share lessons from SIM, so they can be used by other states. If you'd like to read that paper, a link was included in the invitation to today's webinar, and we'll also send out with the recording of today's webinar in a follow-up email.

For our research, we examine the processes of several Round 1 and Round 2 SIM states. In some cases -- such as Massachusetts and Minnesota -- the states had existing quality measure alignment efforts before their SIM initiatives began, which continued during the periods of their SIM awards. In other cases, such as Connecticut, Rhode Island, and Washington -- whom we'll hear from later today -- states undertook their measure alignment efforts during their SIM initiatives to support their health system transformation goals.

Across those states we identified several key steps those states took to develop multipayer common measure sets, which we see here on this slide, and which I'll present today as kind of a road map.

Among the first steps in undertaking multipayer quality measure alignment is determining a strategy for how to engage payers. Of particular interest here is how to persuade commercial payers to participate, in contrast with public payers such as Medicaid and public employee health plans, which state government typically has much more control over.

The biggest distinction here is between voluntary and mandatory alignment strategies. Under a voluntary alignment strategy, commercial payers are encouraged to align with the common measure set, but they're not required to align with it. Under a mandatory alignment strategy, commercial payers are required to align with a common measure set.

The decision of whether to pursue a voluntary or a mandatory alignment strategy may be influenced by the policy leverage available to the state, as well as other factors such as whether a state has the culture or infrastructure to support either of the two strategies.

Looking at the mandatory strategy, we found that states employed two different authorities. Massachusetts and Minnesota used the statutory authorities, with their legislatures passing laws

requiring quality measure alignment by commercial payers under certain circumstances. Rhode Island used regulatory authority, with the state office of the Health Insurance Commissioner setting regulations requiring commercial payers to use aligned quality measures.

Additionally, we found that states employed two distinct forms of mandates to achieve alignment. Positive mandates require the use of measures from aligned quality measure set by commercial payers, whereas negative mandates prohibit the use of measures unless they're included in an aligned quality measure set.

Connecticut and Washington are examples of states that took a voluntary strategy for persuading commercial payers to align with common quality measure sets. One of the key tactics under a voluntary alignment strategy is to build buy-in for the process and measure set by engaging stakeholders. It's worth noting that mandatory alignment states also emphasized stakeholder engagement to support their efforts, but developing buy-in is really a cornerstone of the process in voluntary alignment states.

Another tactic we saw in voluntary alignment states was using state purchasing authority to jump start adoption of the state's common measure set. For example, a state may commit to using measures from its common measure set in Medicaid and the state employee health plans, demonstrating to commercial payers that many providers in the state will already be focused on those quality measures as a way to encourage those commercial payers too to adopt them.

I want to briefly return to mandatory alignment, to give two examples of how states have approached that. In Minnesota, the state used a statutory negative mandate. There, the legislator passed a law prohibiting commercial insurers from requiring that providers report on measures unless they were included in the state's common measure set, basically telling payers you don't have to use these measures on the common measure set, but you can't require that providers report on other measures.

In Rhode Island, the state employed a regulatory positive mandate. There, the office of the Health Insurance Commissioner requires that commercial payers use applicable measures from the state's common measure set and value-based payment arrangements. In the case of Rhode Island, they also use a negative mandate, prohibiting commercial payers from using measures that aren't included in the common measure set.

Another early step in developing an aligned quality measure set is articulating a rationale for why it's needed, and what the state and other stakeholders hope to accomplish by aligning along a common set of quality measures. Common examples of alignment goals from the states we examined are reducing burden on providers by paring down an ever-growing list of measures to something more manageable, furthering the shift to value-based payment by encouraging payment based on quality measures, and promoting quality transparency for consumers, often by publishing providers' performance on measures from a common measure set.

One place the states vary is when and how they lay out their alignment rationale. In some cases, the states' rationale is determined before stakeholders are engaged in developing a measure set. Then the rationale can be used as a type of sales pitch, making the case for why stakeholders should join the effort to develop an aligned measure set.

In other cases, the alignment rationale is established as part of a stakeholder-led measure development process. By offering stakeholders an opportunity to determine the goals, it can help to develop buy-in, and to ensure the measure set reflects various stakeholder priorities.

Additionally, some states have taken a mixed approach of selecting some priorities prior to engaging stakeholders, and then working with stakeholders during the workgroup process to fine-tune and add additional priorities.

Minnesota provides an example of the rationale for alignment being named -- at least in part -- before the stakeholder group is convened. The legislation authorizing the aligned common measure set named specific goals of containing provider burden and promoting quality transparency. In Connecticut, the stakeholder workgroup to develop the state's common measure set also helped to lay out the rationale. They established 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.

Another early step in setting an alignment scope, essentially what should the common measure set cover, and how? That includes the payers, for example. Will the state use the common measure set in its Medicaid program? What about the state employee health plans? And it also includes programs. For example, will the state use the measures from the common measure set in specific programs, such as value-based payments in accountable care organizations, or in transparency efforts to publicly report on provider performance?

Another consideration are the levers or the methods for pushing alignment. For example, will Medicaid managed care contracts require that plans use the common measure set in determining payment?

Washington state provides a good example here. Although Washington has taken a voluntary approach to alignment with commercial payers, it also has bolstered its common measure set by using in-state purchasing of healthcare. In Washington, the legislature passed a law requiring the common measure set be used in state purchasing of healthcare, such as in the Medicaid program and public employee health benefits, which my co-presenters in Washington will discuss in a little bit.

Each of the states we studied employed a stakeholder workgroup to help develop their aligned quality measure sets. The workgroups provided a way for states to cultivate buy-in for the effort,

and to solicit input into broader priorities and specific measures from important constituencies. Workgroups typically included representatives from various types of stakeholders such as commercial and state payers, state agencies such as insurance departments and Health and Human Services departments, healthcare providers including physicians and hospitals, consumers or consumer advocacy groups, and sometimes groups such as labor unions, self-insured private employers, and quality measurement experts.

In some cases, state agencies convened the workgroups themselves. But in other states, other trusted third-party organizations convened the group on behalf of the state, because of their credibility and experience bringing together partners on issues related to quality measurement.

States also varied in who held ultimate authority over the measure sets. In states with a mandatory alignment strategy, the workgroup typically provided recommendations to a state agency which has ultimate decision-making authority over which measures are included or excluded. In states with a voluntary alignment strategy, workgroups themselves may determine which measures are included or excluded since it is a voluntary measure set.

Here you can see across our five study states that the variation in who convenes the workgroup, and who has authority over the measure set. In some cases, like Massachusetts and Rhode Island, the state agency both convenes the stakeholder workgroup and holds ultimate authority over the measure set. In other cases, the state may split those responsibilities across different entities.

In Rhode Island, the office of the Health Insurance Commissioner, which holds ultimate authority over the state's alignment requirement, convenes the state's workgroup. In Connecticut, the workgroup was originally convened by the SIM program office. After the state's SIM initiative ends, Connecticut plans to continue its measure alignment effort through its recently-formed Office of Health Strategy.

In Minnesota and Washington, the states contracted outside third-party ((inaudible)) to convene the workgroups. In Minnesota, the state works with a quality measurement organization, Minnesota Community Measurement. In Washington, the state works with an organization that operates a voluntary All-Payer Claims Database, the Washington Health Alliance.

One of the first tasks in selecting the measures for inclusion in a common measures set is to identify measure selection criteria. The purpose of measure selection criteria is to allow for a systematic evaluation of quality measures that are under consideration according to whether they meet pre-determined standards. It also prevents arbitrary decisions of whether to include or exclude certain pet measures which could undermine stakeholder confidence in a measure set, and limit its adoption.

Across our study states there is substantial overlap in the domains and the specific selection criteria that states used. Some of the most common were opportunity for improvement such as whether there is a gap between actual and actual performance for many providers and whether there is performance variation across providers, proven or consensus measures such as whether measures are endorsed by the national quality forum or other measure stewards, and whether measures are evidence-based and are known to be reliable and valid, containing burden such as prioritizing data that are already collected vs. new data collection and how practical or feasible it is to collect data at the current time, and measure type such as whether there is a preference for outcome vs. process measures.

Another key step in developing a common measure set is developing an inventory of quality measures to be considered for the common measure set. That typically includes measures already in use by commercial and public payers in the state. It may also include other measures of priority issues in the state, such as quality measures pertaining to diabetes or opioids for example. In some cases to contain provider burden, measure alignment workgroups also prioritized measures that already are used by multiple payers in the state.

One way to inventory quality measures and assess existing alignment is through a spreadsheet such as shown by the table on this slide. That approach can highlight existing alignment, and it can help to identify where payers use slight variations on similar measurement concepts, which can be low-hanging fruit for attaining alignment more easily.

After developing an inventory, workgroups score each of the measures under consideration according to how well they meet the state's measure selection criteria. That again can be done using a spreadsheet such as the one shown on this slide.

After evaluating measures according to measure selection criteria, workgroups have selected measures and developed them into measure sets. In creating those measure sets, states have used a variety of considerations. Should all measure selection criteria weigh equally, or should some carry more weight? For example, if using NQF-endorsed measures, a top selection criteria that really matters more than others, do the measures sufficiently meet the state's measurement priorities and goals? For example, if part of the rationale for measure alignment is supporting public transparency, are the selected measures meaningful and understandable to consumers? Should the measures be organized into different measure subsets to meet different goals? That's something I'll discuss here in a little bit more, in a moment. And who has ultimate authority for establishing and maintaining the measure set? Basically will the measure set decisions from the workgroup determine the final measure set, or will these simply be recommendations to be considered by another body such as a state agency?

As examples, to address its priority for combating the opioid crisis Rhode Island added a measure of appropriate opioid prescribing to its common measure set, and Connecticut is investigating ways to quantify disparities within quality measures to address its goal of improving health equity.

States also created measure subsets for different purposes. For example, Rhode Island has core measures for mandatory use by commercial payers, and a menu set of measures for optional addition measures that payers may select from, but they aren't required to use. And Connecticut has a core set of measures intended for use in value-based payment arrangements, reporting measures which are designed for use only in transparency and not necessarily for use in payment arrangements, and another set of development measures for future consideration. That development subset of measures can be useful as a sustainability tool for guiding regular updates to the aligned measure set.

Finally, states vary in how the measure sets are finalized. For example, in Rhode Island and Minnesota, workgroups make recommendations to state agencies which make final decisions on which measures are included. In Connecticut where alignment is voluntary, the quality council of the workgroups that selects the measures also determines which measures are included in the final measure set.

The final ongoing set in the quality measure alignment process is to establish a method for sustaining the measure sets. That's important because measure sets can become stale without regular updates for a variety of reasons, such as providers topping out in performance where they no longer have room to improve on a given measure. Evidence changing - either evidence supporting the measures themselves or the healthcare practices that those measures promote. The feasibility of measures may change over time. For example, allowing a shift from claims-based to clinical quality measures. And quality priorities may change over time as well.

So each of the states we examined has developed processes to revise their measure sets on an ongoing basis, making marginal changes such as retiring and adding new measures, but also periodically re-evaluating their measurement priorities.

One tangible example of states refreshing their common measure sets to address changing priorities is Washington, which saw an opportunity to use its common measure set to address the opioid crisis, adding multiple new measures of appropriate opioid prescribing during one of its annual updates to its common measure set.

With that, I'd like to segue to the next portion of our agenda, where presenters from Washington will discuss their experience with quality measure alignment. I'll be available at the end of this webinar for questions, but now I'd like to hand the presentation off to my colleagues in Washington, starting with Bonnie Wennerstrom.

Bonnie Wennerstrom: Hello everyone. Thanks so much for having us today. Just to introduce myself, my name is Bonnie Wennerstrom. I'm the Healthier Washington connector at the Health Care Authority, and I'm also the former SIM director of Washington state. I'm going to provide a very brief overview of Washington's SIM initiative, and then turn it over to my colleagues Laura and J.D. for a deeper dive.

So Washington's SIM Round 2 grant which catalyzed the Healthier Washington initiative was implemented in February -- oh, sorry -- from February 2015 through January 2019. SIM funding catalyzed a large body of health system transformation work led by the Health Care Authority, but in partnership with many other entities. The Health Care Authority is the state Medicaid agency and largest purchaser of healthcare in Washington, which puts us in a position to implement innovative strategies.

This diagram shows the three over-arching goals of Healthier Washington. Ensuring care focuses on the whole person, improving how we pay for services - or paying for value, and building healthier communities through a collaborative regional approach.

Washington's SIM initiative was broad and far-reaching in its strategies. To call out a few, we created regional accountable communities of health, we worked to integrate behavioral health into managed care, and we worked to implement several payment redesign strategies to pay for value instead of volume. While the SIM period has ended, Healthier Washington continues through these strategies.

Measurement is a foundation that supports all of our delivery system reform strategies. The measures in our common measure set are focused on promoting alignment among payers to reduce overall burden on providers. Also it guides how cost and patient experience can be drivers of the quality healthcare. Today we want to highlight how we've leveraged the common measure set to use our purchasing authority to drive quality in healthcare in Washington State.

Now I'm going to turn it over to Laura to talk about how we developed the common measure set. Thanks very much, everyone.

Laura Pennington: Thank you Bonnie. My name's Laura Pennington, and I currently lead the development and the ongoing evolution of the statewide common measure set here in Washington State. So I'm happy to be with you all today to share our journey in how we developed a statewide common measure set here in the state of Washington.

So we're very fortunate in Washington to have organizations who are leaders in tracking and publicly reporting performance indicators to help drive quality in healthcare. And it was because of these successful partnerships with health systems, health plans, provider organizations, and numerous others, that we were able to develop and sustain the Washington state common measure set on healthcare quality and cost for the past five years. There's a link at the bottom if you're interested in seeing not only our current common measure set, but other materials related to the development of the measure set.

So let's start with the beginning first to understand why we decided to develop a common measure set. Colin covered a lot of the reasons that we have, and we're not dissimilar to some of the other states. But as you know, in a highly-functioning healthcare system everyone would receive a similar high level of evidence-based care for the same condition. However we know this is not the case in Washington or elsewhere around the country.

So we recognize that an important first step in reducing variation is measuring it and broadly sharing results to develop a common understanding of what needs to improve, and where it needs to improve. So in 2014 through the same legislation that established the Healthier Washington or SIM initiative, there was also a mandate to develop a statewide common measure set.

The main purpose of the measure set is to standardize the way we measure performance, reducing the reporting burden on providers, some who at the time were reporting to up to 150 measures through multiple contracts with payers. It's also to promote voluntary alignment of measures, sending a common signal to all payers in Washington, not just those that the state currently contracts with - Colin mentioned the commercial payers and the voluntary alignment. And also to publicly share results on an annual basis through the APCD - the All-Payer Claims Database. We actually have two in our state. The voluntary one that Colin mentioned and the mandatory one that's managed by the state. This is to provide a distribution and comparison of performance information for multiple audiences such as consumers, providers, purchasers, and policy makers.

So those were our initial reasons for having a statewide common measure set. There's also some additional purposes of the measure set that we realized later. The biggest one is as the state, we realized that we could leverage the common measure set as our North Star on the path to performance-based arrangement. So we really use the common measure set for what are those measures that we put into our value-based payment arrangements with our providers and plans.

So the process that we used to develop the common measure set relied heavily on the input of many different types of stakeholders over a six-month period in 2014. So the Governor-appointed Performance Measures Coordinating Committee -- which I'll refer to as PMCC from here on out because it's kind of a mouthful -- was made up of representatives from the Medicaid and commercial health plans, practicing providers and provider organizations, employers, purchasers of healthcare both small to large, public health, education, tribal organizations, measurement experts, quality experts, and numerous others. And although the state oversees the common measure set, we contracted with the Washington Health Alliance to convene the PMCC as well as three ad-hoc workgroups.

It was through that agreement and that relationship with the Washington Health Alliance that the state could kind of take a backseat. And so we weren't seen as the state telling everybody what to do, because the Washington Health Alliance, they were an unbiased third party. So that worked out really well for us. And they were also the owners of the voluntary APCD, so they've been working with these organizations for a long time. So they had already had those established relationships.

And so the three workgroups -- three ad-hoc workgroups -- utilized subject matter experts who reviewed measure to address prevention of chronic illness and acute care. And overall the workgroups reviewed a total of over 300 measures, but ultimately only submitted 15 measures each to the PMCC for consideration. So it was a very difficult process to narrow it down to only 15 each.

And the workgroups and the PMCC used -- and still do -- a standard set of measure selection criteria which can be found on our Web page, which includes consideration of nationally-vetted measures. That's the priority first. We want to ensure that each measure has a robust data source to support it, and also looked at different units of analysis. Are the measures reported by the health

plan? Do they report it at a statewide level, county level, provider level, etc.? And the provider level is medical groups of four or more providers.

And then we also allowed for public input at all times through email, written correspondence, time set aside during the PMCC meetings, as well as formal written public comment period among others. And trust me, we received a lot of public comments.

So of course we faced challenges along the way as well. So here's a few. We struggled with keeping the total number of measures reasonable, especially since the legislation originally called for no more than 34. So the original measure set had 52 -- a long way from 34 -- and today the 2019 measure set includes 66. So again, almost double the original 34.

So another challenge we had was practicing providers were not actively engaged in the conversation, as schedules were difficult to accommodate. So they felt left out of the conversation, which we heard a lot. There was a lack of understanding of the purpose of the measures, and confusion about which measures are appropriate for contracting vs. monitoring activities, or just reporting.

There was a lack of buy-in within state agencies to use the common measure set, including our own state agency, the Health Care Authority. So it took a lot of nagging and ultimately a policy to get divisions to use the common measure set in their contracts.

So beyond that initial development of the common measure set, the ongoing engagement of the PMCC was also a bit challenging as membership changed and the scope continually needed to be refined.

So lessons learned - we have many. So number one is to not lose sight of the forest for the trees. What that means is really establishing a clear goal and purpose statement from the beginning that

is relative to all potential end users. We had that initial sight set on developing a measure set for our contracts, but we found that there were a lot other uses and a lot of other users that we didn't really see initially. And so what happened is we didn't build a strong communication strategy early that considers different messaging for different users, hence the confusion about the different uses for the common measure set.

So another lesson learned is find those critics early, and engage them by bringing them into the discussion. Because there will be critics. We had many. I can't tell you how many times people complained about the measure set, and when I invited them to attend the meeting and provide direct input before the committee votes, they backed down. So include them in the discussion. Find a way to get the providers to the table, even if you have to have early morning or evening meetings. Ultimately they're the ones that have to implement many of these measures. They are trying to do their best, so it's important to hear directly from them about what is working and what isn't. So if you didn't get it the first time, there's no such thing as over-communicating the purpose and intent of the common measure set.

Also one last thing - be prepared to revisit a topic if you hear from any particular stakeholder group that the set of measures does not adequately address it. Our first year after the development of the first measure set, we revisited behavioral health. Because at the time there weren't a lot of really good nationally-vetted behavioral health measures. So we re-addressed that, and ultimately because we were prepared to modify our own rules if needed, and we worked with a partner organization to develop measure to support the needs of our behavioral health population. So while the one of our measures is to not use home-grown - or one of our criteria is to not use home-grown measures, we broke that pretty quickly. So you have to do what you have to do.

So sustaining the common measure set - the original legislation actually included a requirement to develop a plan for the ongoing evolution of the common measure set. That plan was developed in 2015 by the PMCC, and includes an annual evolution of the measure set, which we've done that

every year. So what that evaluation group does is they look at are there any HEDIS changes? Any changes to the specifications? Do we need to swap any measures out? Is there anything that we've topped out on? Anything that's not working? Should we look at adding any additional measures? That's what that group does every year. And then we'll continue to work with commercial payers to ensure that voluntary alignment, particularly with the value-based payment or the performance-based measures.

And then one of the questions we continue to ask ourselves is how do we continue to ensure we are using the right measures to drive quality? So within the Health Care Authority, we've developed what we call the Quality Measurement and Monitoring Improvement. So when you think about how we continue to ensure we are using the right measures to drive quality, externally we have the PMCC and the statewide common measure set to inform our work. Internally we use the QMMI process - or the Quality Measurement and Monitoring Improvement.

This is a process made up of different workgroups or teams that regularly track and monitor performance and updates to national measure specifications, and annually review the measures and contracts that are specifically tied to BBP, but we do look at all of the measures to ensure that they still meet our goals as an agency. And you can kind of see the visual here. I know there's small lettering, but we can get you a copy of that if you want to learn more.

But the advantage to having a program like QMMI is to ensure alignment of a common set of measures across contracts to ultimately drive quality and value as demonstrated in the slide before you. It is a bit busy, but you can get the general idea of the crossover of measures in our performance-based contracts.

So now I'm going to turn it over to J.D. to talk about how we are using these common measures to support our value-based purchasing strategy.

J.D. Fischer: Thank you Laura, and thank you Bonnie. So my name is J.D. Fischer. I am the value-based purchasing manager here at the Health Care Authority. And one of my main responsibilities is to help us as an agency coordinate all our purchasing strategies to advance a one-HCA philosophy across our books of business. Those include Medicaid, public employee benefits, and school employee benefits.

So I'd like to provide an overview of who we are and what we do at the Health Care Authority, and how quality measurement and performance improvement are integral to our value-based purchasing strategy. As Bonnie mentioned, we are the largest purchaser of healthcare in the state with an annual spend of over \$12 billion, purchasing care for roughly 2.5 million individuals.

As the largest purchaser in the state, we've taken it as an imperative to leverage our purchasing power and drive health systems transformation. We believe that changing the way we pay for care will help drive that change, and accordingly we've set pretty ambitious value-based purchasing goals to continue linking payment to quality and value.

By 2021 in partnership with purchasers, providers, and payers, we will shift 90% of provider payments through state-financed healthcare programs into value-based purchasing arrangements.

We're having a little trouble advancing the slides here. Well, while we get that figured out, imagine just a glorious depiction of a road map aligning all our programs and achieving our goals. It's quite beautiful.

But we purchase - or we publish an annual value-based roadmap. Not this one. Well we publish a roadmap each year that shares progress along the way and highlights new initiatives in the works. As you can see, we aim to get to 90% by 2021, and we started this work - we set the initial target in calendar year 2015, and starting with 20% in 2016. So after two years of monitoring this and working towards this goal, we've actually exceeded our annual targets quite considerably.

Our purchasing strategy is built on six guiding principles, all stemming from the quadruple aim of lower costs, improved outcomes, and better consumer and provider experience. We're committed to advancing a one-HCA purchasing philosophy that aligns initiatives and strategies across our three books of business. Again, that's Medicaid, public, and school employee benefits.

For example, we use the same home-grown quality improvement model that rewards both quality improvement and quality performance. We use that model both in our accountable care organization product -- our ACO product -- in our public employee benefits program, and in the BBP component of our NCO contracts.

As Laura mentioned, we do strive for alignment in quality measures that we use across all our various contracts. And as noted on one of her slides we do have six quality measures included in each of our BBP contracts. In general, our BBP strategy emphasizes quality improvement over cost reduction. This is based on the idea that improving quality will improve health outcomes, which will then lead to lower expenditures down the road.

To give you a snapshot of how we are holding health plan and provider partners accountable through our purchasing, this is a brief list of some of the major contract changes and initiatives we've developed over this past several years. These examples span our three books of business, and I want to re-iterate the intentionality behind the alignment of quality improvement and performance measurement in the strategies that we've implemented across these initiatives.

There is significant overlap in the provider networks that participate in our three books of business, and so we believe that by aligning the quality measures and the quality improvement expectations across our contracts, that we are supporting providers and lowering their administrative burden, and giving them similar and aligned expectations across contracts. This is a message we trumpet loud and often to other purchasers and payers in hopes that other partners and other purchasers

and payers across the state will strive to align their quality expectations accordingly, support our providers, and help improve the general health system performance across the state.

Looking ahead, we'll continue to drive towards a health system that truly addresses whole-person care, keeping primary care at the center through clinical and financial integration. Our long-term transformation must focus on the social, physical, and behavioral health needs of all Washington residents, and empower them to find the care they need when they need it.

We're emphasizing the coordination of care across sectors and care settings to ensure that there is no wrong door through which patients may receive necessary care, and we want to require financial flexibility, robust data sharing, and collaborative leadership that leads to greater efficiency and improved outcomes.

We hope that some of the tools like the All-Payer Claims Database will help us achieve these goals. And also in partnership with our state legislature, we are altering the way the quality measures are included in the MCO contracts. And beginning in 2020, we will have a set of quality focus measures for each MCO that focus on areas of particular need for improvement. So we're looking forward to how that might change the landscape in how we address quality improvement in our state.

And that's it for Washington. Thank you all very much. Thank you Colin and SHADAC for the opportunity to speak today.

(Carrie Al Young): All right. And now we're going to hand the call over to the folks at CMMI, Jennifer and Greg. Can you, okay, there we go. Yes, if you guys want to take it away?

Jennifer Lloyd: Yes, thanks. Hi, this is Jennifer Lloyd. I work that the innovation center, and I worked on the SIM Round 1 evaluation contract. And in Round 1, we had six states, including Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont. And so we just wanted to bring some of

those lessons learned from that evaluation related to quality measure alignment across payers into this discussion.

So among Round 1 states - and the slide will catch up in one second hopefully. I know there's a delay, but it seems like it's - oh, there we go. Great. So among the Round 1 states, there was really only one state that was able to successfully align quality measures across the major players in the state. This was mostly done in conjunction with creating a multipayer accountable care organization model built on top of multipayer patients in our medical homes. So there was, like, a lot of history with the state working across these payers already that helped create that alignment.

Most of the other states -- including the four states that created Medicaid ACOs -- really ended up having to align with pre-existing efforts in Medicare and in commercial -- especially ACO -- areas with high-ACO penetration, as that kind of already had heavily influenced providers in the market. And so the Medicaid ACO was kind of coming in after this prior reform, and really had to kind of align with what was already in place.

Vermont was able to develop this single set of statewide outcome measures in quality, and most of which is being used by the ACOs across those three payers. They were able to do this by trying to tackle some of the hurdles that providers experienced - for example, small providers lacked resources and infrastructure necessary to report on certain quality measures, and so Vermont used some of their SIM resources to offer sub-grants to these small providers and ACOs to be able to kind of build up that infrastructure that they needed.

And so these were some of the kind of ways that states in Round 1 used - kind of more carrot approaches, especially within a voluntary framework. Where states used mandatory approaches for state-financed healthcare, the alignment across quality measures was able to be achieved, but only for a small number of payers. So this is really just ending up covering a very small proportion

of the population in the state, and means that providers really still continue to base the burden by and large of multiple payers with multiple quality measures.

And I wanted to bring forward some of the barriers that providers have been talking about in Round 1 states, because I wanted to unpack that a little bit further. So a number of providers talked about the burden of submitting data to multiple quality reporting systems - not just that there's different quality measures, but there's different systems that they have to use to enter these various quality measures. And providers found it very burdensome even to produce a slightly different modified version of essentially the same metric, based on just very idiosyncratic requirements that individual payers had within the state.

The burden also related to the volume of work that was imposed to report quality measures, and often stems from many individual providers didn't recognize the benefit of reporting this information. And so what a number of the Round 1 states were really able to tackle was helping providers see the value in reporting this information.

And so if you think about a shared savings model -- or a model where any of the savings accrues to a convening organization like an ACO -- those individual providers may not see the shared savings distributed to themselves, and may not even be aware they're in the model. I know a number of Medicaid providers in ACOs in these states were not aware that they were a part of the model, or were not aware they were a part of the ACO.

But they were aware of the Medicare requirements, and they were aware of the commercial insurer programs that have been longstanding, and so were more focused on the measures in those Medicare and commercial models, and that were reporting on the burden related to that. So that was something maybe the state couldn't necessarily control, but was still impacting the provider, especially where the state was not able to get a multipayer model launched.

And few of the models that the states launched during this time were a pay per performance type of model. And so those incentives related to quality were really not tied to payment. And so that also creates kind of this long distal incentive for providers to understand the impact of their work on the quality measure.

Shared savings models often have a retrospective calculation, so the data collection in the reporting periods and the review of quality happen long after the provider is working with that patient. And so that really limits the provider's ability to make changes to their care delivery patterns and really limits their ability to improve quality.

And so some of the frustration really stems from that - that this report is so outdated, I'm not sure it's even relevant for my patient population, because the information is at an aggregate level. And so what do I really do about that? And so some of this frustration might not be the multiple measures itself, but just the inability to make improvement or to be actionable on that information.

And so providers in Round 1 states actually really appreciated some of the other work that we've done. And so while the states couldn't maybe align quality measures, they did start providing data feedback reports on Medicaid patient panels to the providers in their model. And where the providers felt like that was an accurate representation of their patient panels and where that information was timely, those providers found it to be much more useful to take action on the quality of care they're providing.

We have a number of great quotes from providers across these states saying, you know, "I thought I was doing a good job for my diabetic patients, but when I was looking at these feedback reports I was seeing I actually wasn't." And so, you know, it helps them make an actual change, and that wasn't necessarily tied to financial incentives that made them feel like they were doing what they want to do as providers, is improve the quality of care for their patients.

Let me just quickly transition to the next slide, which will take a second. But so all of the Round 1 states invested resources in quality measurement reporting. And so although the kind of alignment across payers was not successful, all the Round 1 states were fairly successful in providing timely feedback reports to their Medicaid providers, which in many cases those Medicaid providers had not had that type of view of data and of their practice patterns previously. And so that was seen as a huge benefit.

And providers -- I'm sorry, hold on one second -- so getting back to the providers viewed increased use of the quality metrics as useful in principle, but overly burdensome as implemented. And some of that burden, again, it might be too hard for the state to take on across multiple payers where they only have control over maybe the Medicaid or the state employee populations.

And in Round 1, you know, many of the states had started to try and convene workgroups to produce that alignment across different payers, especially where pre-existing models were in place. But often this resulted in not a consolidation of measures, but a proliferation of measures as each of the individual payers wanted their own metrics to be included. And so it really didn't result in a lower amount of measures for providers.

States again as I mentioned kind of pivoted and changed their alignment strategies moving forward, and focused on other efforts to try and reduce burden for providers, and help providers participate in these Medicaid models. Some of those efforts included making healthcare cost and quality data transparent to the public. And so states that initiated this type of effort have continued to do so.

And in some cases these reports have helped create some competition among providers as this information is out there, and they can view their performance relative to measures for other providers. And some of that has motivated providers to improve relative to their peers. It's also allowed for the larger convening organizations to explore the data for best practices for

improvement on quality metrics - so to see where they're doing well, and to see where they're not doing so well.

And as I mentioned previously, most of these models were not pay per performance. But where they were, those were the quality measures we saw improvement in. So where a quality measure was tied to a payment outcome or where there was a feedback reporting system in place for providers to see how they were doing -- so the providers had to see the data feedback was valuable, that their reporting on these quality measures was valuable -- those two things kind of seemed to coalesce around improvement in the quality measures. And so that's something else to think about, is if we can't remove burden, how can we make providers feel like what they're doing is more useful?

And then there's a couple of other considerations I wanted to throw out there for thoughts. And some of these might be discussed in the next section on Round 2. But, you know, there's larger efforts that are underway that states and providers are already thinking about, related to MACRA, related to other Medicare models, and to the (SST) program. And so in many ways it just makes sense to align with what is out there, even if there are some frustrations with what measures are being reported in those larger programs.

There is also a Medicaid scorecard that's been released by CMS. And so states and providers and really anyone in the public can take a look at quality measures across various states. And this might be something interesting to look at, in that many Medicaid ACOs operate in multiple states, and so they have their business not just in one state, and they don't want to make decisions necessarily that are just based in one state. So you can take a look at this tool online, and see what other quality measures are already being reported by states and how states are faring on that. And so that kind of gets back to this kind of public transparency piece where we can start, you know, once we have this data flowing we can see how we're doing, and then we can also kind of compare ourselves to our peers.

And then beyond stakeholder engagement which states in Round 1 initially focused on and then pivoted, we seem to see a little bit more control and movement in other ways that states used to help infrastructure -- or to help IT infrastructure -- in their state to improve how the reporting itself went - to make that more seamless, and then also provide those feedback reports to bring about better alignment or to reduce burden. So as I mentioned, the data feedback tools were really, really helpful. So where you don't have a pay per performance model and where you don't have providers, like, really focused on something because of payment, you may be able to help them by just providing more timely views of their data.

And so with that, I'll turn it over to my colleague Greg Boyer to go through the Round 2 lessons learned.

Greg Boyer: All right. Thanks, Jennifer. Let me just - my slide. All right. So as ((inaudible)) said, I am the lead for the Round 2 evaluation for SIM. Round 2 is actually still ongoing, so we don't have quite as concise of a story -- or complete of a story -- as Round 1 provides. We have three reports so far for the evaluation that are available on the Innovation Center Web site. And so I'm going to give you just a snapshot of kind of early struggles, some more recent updates, and then the most recent updates of where states are, and their QMA strategies.

I should note that the Round 2 has 11 model test states, and they are Colorado, Connecticut, Delaware, Iowa, Idaho, New York, Ohio, Michigan, Tennessee, Rhode Island, and Washington.

So to get into the early struggles in Round 2 states, as expected there were multiple sources including loss of competition around the EHR, and lack of a standardization, especially in the Medicaid/Medicare organizations base. And providers noted many differences with the EHRs and how they collected and stored data differently. And this led to complications around the development of standardized definitions for numerators and denominators.

SIM is supposed to be multipayer, and so there's a lot of diverse populations kind of under the states' attention, and what they can do and what they cannot do. But part of that is perhaps some pushback regarding measure sets that were tailored for one population being used for another population. That includes in Iowa where they had the Wellmark VBP model -- or valued-based payment model -- and they tried to adapt it for the Medicaid program. And with those two different populations there was some pushback as to the appropriateness of this strategy. I apologize for the siren in the background if folks are hearing that.

Also there were concerns around quality alignment in already-existing systems. And kind of what was going on in this space outside of SIM and outside of this specific activity at the time - for example, six states wanted to align their core quality measures with those core quality measures released by CMS to come in February of 2016. However, the timing of that did not quite sync up as states had predicted or had hoped, and so they had to move on with their own work in this area.

To get a bit more recent in our - in QMAs first in Round 2 states, states took advantage of their powerful lever in terms of their Medicaid payment space. And stakeholders view this as a possibly effective approach, because if they could get it right in Medicaid, they might be able to demonstrate a value proposition for alignment to other payers and providers. Of course, there was that concern I listed on the previous slide around the appropriateness, but I think states took their status here as a payer and as a provider in terms of Medicaid and wanted to make their mark there, and see if they could spread it. This is especially notable in states where Medicaid initiatives were predominately involved in their state's award.

Also, states having learned some lessons from those early days, they tried to work in some flexibility around what was going on in their healthcare space. And this included working around Medicare models. For example, in Ohio they -- it might be Colorado, it might be I had my states mixed up but -- there was an openness to just adopting what CPC Plus was doing in that state, and then working

from there and adding on measures from there that the state could use for their benefit as well. But not to necessarily start from scratch, but to see what was out there and to build from that.

And then some states moved away from these state defined measures in order to be more applicable on the national scale. So there was some hesitancy in the commercial space about using state-specific measures if a commercial payer is operating in multiple states, or for that matter across the country. So states here allowed these payers to work with what they've agreed upon was their national measure set, and states have worked around that. And Connecticut is a nice example of that - where that occurred.

And then finally, states are really maturing in this space in terms of how to get user resources, and how to provide feedback and help to those providers and practices that may still need a bit of handling. So in Colorado, providers reported that practice facilitators and clinical health IT advisors helped them better understand the use of data, and managed their quality measure issues.

Also, Tennessee in terms of providing specific feedback has a nice example here, where they actively solicit provider feedback through what they call their Technical Advisor Group, or their TAG. And they have monthly calls. They keep in touch electronically and have in-person meetings as well as annual episodes designed feedback. They're held in several sessions across the state.

And finally, states have taken on the role as a convener in terms of combining these measures across payers where applicable. So Ohio isn't completely managed care in their Medicaid space, but they have been able to link their fee-for-service Medicaid with their MCOs -- which are numerous in Ohio -- and provide these reports to the providers in a more sustained and a more effective manner.

And so with that, I think I will hand it back to the folks at SHADAC.

(Carrie Al Young): Hi there. This is (Carrie Al Young) again at SHADAC. Thank you to those of you who have submitted questions already via the chat feature. Please continue to send them through. We're going to start in on that right now.

And we'll start with a question -- kind of a technical question -- for Washington. This is for - regarding the graphic on percentage in value-based purchasing. Can we go back to that slide? Sorry, we're just going to bump back. It was, yes, it was the roadmap one I believe.

The question coming for you which is wondering if you could walk us through this in more detail - talking about the lives under value-based purchasing risk, and how this relates to total system reimbursement at risk under value-based purchasing.

J.D. Fischer: Sure. So this graphic and the percentage goals depicted in the green boxes only relate to state-financed healthcare programs. And of those programs, on the Medicaid side it only includes managed care. So we still operate a fee-for-service program that covers a lot of the covered lives through the tribes, and also through our eligible population. So we're not considering those in the denominator for these targets, but it includes all managed care lives, and all lives that are involved in the public employee and school employee benefits programs.

So the denominator is also the total dollars paid to providers in those programs. So for example, on the public employee benefits side we have multiple benefit options for employees to select from. That includes a self-funded program, and then one fully insured benefit option. For the self-insured option, that's where we are operating our ACO product. So employees have the option of selecting that product. If they do select that product, their payments to providers made under that will go into the numerator for these targets.

Similarly, on the fully insured side, that is an integrated health system. And they report an annual value-based purchasing survey to us, and we take their findings on their large group market across

the state, and apply that to our business. And the dollars under that contract also go into the numerator.

And then for the managed care organizations, they report to us annually on their payments to providers in the form of value-based contracts.

Is that getting to the answer, or answering the question that was asked?

Colin Planalp: Yes, thanks J.D. This is Colin from SHADAC. I have a follow-up question about that. So on this roadmap where it says, for example, 90% (DVP) in 2021, is that 90% of covered lives? Or is that 90% of spend?

J.D. Fischer: Yes. That is 90% of the payments going to providers.

Colin Planalp: Thanks.

J.D. Fischer: So it does not include, like, administrative costs and administrative payments.

(Carrie Al Young): Thank you. Next question we have coming in I guess could be initially addressed by Colin. Can you talk about who is responsible for calculating performance for measures, for quality measurement sets? I don't know if we know that broadly or specifically. And then Washington can talk about that as well.

Colin Planalp: Yes. So I think here in calculating performance for the measures in these common measure sets, it kind of depends on the specific use. One use there is in value-based payment arrangements, for example. So in value-based payment arrangements it would generally be the individual payers who would calculate the performance for their own covered lives.

Another potential use of these common measure sets that a lot of states use is in public reporting for transparency purposes. In some cases a state might stratify those by different payer types - so Medicaid vs. commercial. Or they may lump those together into a total performance for different providers. In that case, that may be the state doing that, or that may be another contractor. For example, in Minnesota a group like Minnesota Community Measurement may do that for some of those measures.

So like I said, it kind of depends on the specific purpose for those measures as to who would be calculating those, and for what population.

(Carrie Al Young): And Washington, did you want to chime in on that at all?

Laura Pennington: Yes, we actually agree with what Colin just said. It really depends on the measure, and who is doing the reporting. Here at the state we do some of that ourselves, but it is also done by the plans. And we also have actuaries that we have contracts with who calculate some of that as well. So it really just depends.

(Carrie Al Young): Okay. Right. And this is a question probably best answered -- at least initially -- by Jennifer and/or Greg. When not using nationally endorsed measures such as NQF-endorsed measures, how do you SIM programs rationalize those positions to payers?

Jennifer Lloyd: Hey, this is Jenny. I'll take that, but I don't know that I have an answer, because I'm not sure that among Round 1 states I saw much of that. Yes. I don't know, Greg, if you saw any of that as well.

I mean, so within Medicaid, you know, the state has more control. And you can obviously do things within your state contracting space. But in terms of a multipayer approach, you know, I'm just not sure that - I don't know how well that would go over.

Greg Boyer: Yes, this is Greg. I think - I don't think that came up too much from my memory. But I think if a state can justify in terms of their payment models, that might be the -- excuse me -- that might be the best way for them to go about doing it. I don't know if this came up a whole lot, to be honest.

Jennifer Lloyd: Or if you have a specific example - so I know that there's not always great measures for certain concept that we're still kind of working on - for example, measuring care coordination is something that we use the CAP survey as a proxy to measure, you know, satisfaction with care or care experience. But it's still not a great measure of care coordination.

And so even internally at CMMI and at CMS we've been trying to think through ways of finding better measures of that. And sometimes we have kind of - we start tracking something that's not necessarily tied to payments. This is not financial accountability per se, but it's more of a payer reporting situation, just to try out the measure. But if you don't have, you know, any kind of validated tool book to go to, but you still kind of want to make some headway in a space that's important, we still need data. And so I think maybe you could tweak if the measure itself is tied to a financial incentive. Because I'm sure that that would give providers some pause, if they were being held accountable for something that wasn't kind of nationally endorsed, or didn't have kind of the credibility that comes along with the NQF endorsement.

Greg Boyer: And I...

Colin Planalp: This is Colin. Oh, go ahead Greg.

Greg Boyer: I just wanted to add that, you know, part of what we've seen here -- and I think it was implied but maybe just to state it more bluntly -- and that, you know, states are consistently or constantly engaging their payers and provider communities. And there's been several measures that come into the envelope, but it's also that several measures are also retired.

So there is a lot of kind of circulation, and this kind of life cycle to these measures to some extent. So and I do remember -- I believe -- NQF being a part of this - NQF measures being part of this discussion and process.

I'll turn it back over to Colin.

Colin Planalp: Thanks Greg. So I had a couple of thoughts on this question. First is that these - for what we looked at with these five SIM states, they generally approached this as kind of a collaborative process, where engaged commercial payers, state payers, providers, consumer advocates.

So often the way that states arrived at these measures -- whether they're NQF endorsed or not -- is by different stakeholders -- the state or the payers, the providers -- noting that this is a priority that we have. We think that this ought to be measured in a common measure set. They would often look first toward NQF or other consensus measures, and if there isn't one, look for other alternatives or maybe even develop one.

To that point, I wanted to see if Washington could talk a little bit about their adoption of their -- I believe -- three measures of appropriate opioid prescribing, because that's a case where Washington -- like Rhode Island -- were kind of ahead of the curve in looking to adopt measures of appropriate opioid prescribing when there weren't at the time a lot of good -- and still aren't -- a lot of good options available. So they adopted a couple that weren't NQF endorsed. Could maybe Laura or Bonnie or J.D. talk about that?

Laura Pennington: Sure. I think you hit the nail on the head with saying that the important thing is to have all the right players at the table when these conversations are occurring. This is why our PMCC is so important to the process by having all the commercial payers at the table as well. We may not be able to require them to put it in the contract, but having them at the table when the decisions

are being made and the conversations are occurring is really important to ensuring that alignment down the road.

So with that said, the conversations that are occurring include, you know, what are our goals? Where are our gaps? And what are our needs to find measures that aren't - where there aren't good measure that are nationally endorsed? And so we found that with our behavioral health population, you know, we have the strong goal in Washington State for behavioral health integration. And that happened with mental health treatment penetration, SUD treatment penetration, and later opioid use.

So we rely on a couple different things, one of them being the Bree Collaborative, who they come up with recommendations - sometimes for measures, sometimes just clinical guidelines which we put into our contracts. And in that particular case, they came up with three measures that were adopted by the PMCC. And so those are the measures that we put into contract.

Not too long after that then, CMS came out with some measures. So we ran into that problem. But with the mental health treatment penetration and SUD treatment penetration, there still aren't measures that help us really measure integration of behavioral health. So that's what we're using now. And I think they have been submitted to NQF for consideration by our partner agency.

But you just have to get everybody at the table to have the conversation. And initially when we put them into the Medicaid contract, our commercial payers for our public employees, they agreed to put them into contracts as well. But we have them a grace period of a year, because they're the ones that are calculating the results for those. For the Medicaid we were calculating them for the Medicaid plan.

So it just takes a real team effort of the right stakeholders at the table.

(Carrie Al Young): Thank you. We also have a question coming through for Washington. It's kind of a higher-level question about the extent to how or whether Washington is evaluating the impact of its alignment efforts. Are you seeing improvement on performance in aligned measures, and create voluntary alignment? Do you have any suggestions or lessons learned for states to consider in evaluating and monitoring the impact of alignment efforts?

J.D. Fischer: So I can speak briefly about how we are trying to track and monitor the alignment. So we issue an annual survey to health plans, and then another annual survey to providers, focused on value-based purchasing. Some of the questions we ask in those surveys get at how they - for the health plans, how are they aligning their quality measures in contracts across their own books of business? But then how are they aligning with the common measure set or other initiatives and payers? So we get a sense through that survey.

And then on the providers' side in the providers' survey we ask a number of questions about their experience with value-based purchasing. What are their barriers? What are their enablers? We ask a lot of questions about quality measurement and how health plans and how the Healthcare Authority can support them in that area.

So we're asking these questions. To the extent how this alignment has either improved performance, I don't know that we can say anything quantitatively at this point. But it's something we're tracking and monitoring.

(Carrie Al Young): Great. Thank you. And this is a question that might be best addressed by Greg or Jennifer. How have states treated quality measures from payers over whom they have no control, such as Medicare?

Jennifer Lloyd: I mean, so I guess we could speak - or I could speak to perhaps the next iteration of Vermont's model. So they had a SIM award, and through that SIM award in addition to kind of prior

efforts had built off of the shared state Medicare shared savings program to create a Medicaid and a commercial version of the shared savings programs -- basically an ACO -- in their state.

As that was ending, the state started negotiating with CMMI to create an all-payer model. And so through that all-payer work, the state was able to kind of iterate on how Medicare viewed not just quality, but performance - or how the state kind of performed for their Medicare population, but tied to this kind of agreement that they have with CMMI.

Besides kind of a one-off like the Vermont or some of the other kind of state models like Maryland -- all-payer models -- usually states come in and participate with the Innovation Center specifically through kind of more like standardized models, like the Comprehensive Primary Care Initiative.

And so you really can't in most cases dictate to Medicare. At that point you're kind of coming in and joining what Medicare has already decided to do. And so maybe have some say in the Medicaid space, or maybe you can continue to work with your commercial payers, but really I'm not sure how much room you would have.

And I know the Innovation Center continues to work with some of Round 2 states on kind of a Medicare version of their SIM work. So that would be kind of the only vehicle I can think of.

Greg, did you have any other thoughts?

Greg Boyer: Yeah. So this has come up a bit. And kind of after state were awarded their SIM awards in late 2014/early 2015, the Innovation Center wrote out the CPC Plus Initiative, or the Comprehensive Primary Care Plus Initiative, which is the second iteration -- or the second generation -- of the CPCI initiative - or CPC classic initiative.

Some states have actually take that and used it to their advantage, and are using the CPC Plus participation in their states to take onto - use these measures for their purposes as well. So Colorado and Michigan aligned their SIM initiatives with the CPC Plus Initiative in their states by modifying some of their SIM quality measure sets to incorporate some of those CPC Plus measures.

So yes, the states don't have a lot of push on Medicare, but they can adapt and work around or work with what's in the space in the Medicare book of business in their states.

Colin Planalp: And this is Colin. I have a couple more thoughts to add. So in the work that we did looking at those five SIM states we talked about, we saw basically two different approaches to how states addressed the question of Medicare measures.

On one side, states may just consider Medicare measures as part of that overall inventory. So as they're looking at what existing alignment there is, and trying to leverage that existing alignment.

On the other hand, some states took a kind of an opposite approach, as they just looked at this completely without Medicare measures, saying we don't have really any control over what the Medicare measures are, so we're going to look at this separately from Medicare to see apart from that what measures we do have control over, and where we can improve alignment from commercial and state public payer measures.

(Carrie Al Young): Great. Thank you. And this question I think is best directed to you, Colin. Besides Minnesota, are you aware of any SIM states that include people with disabilities in their measured populations?

Colin Planalp: Yes. So for this question, I believe that any of these quality measures typically would include -- unless the measure specifications exclude them -- individuals with disabilities.

What this question may be getting at is whether any of these states stratify populations by disability or without disabilities. I am not aware of any other states doing that. I know that Connecticut has put a focus on health equity, and looking at disparities in performance and quality measures by different groups. So they may consider this. I just don't know off the top of my head whether disabilities are a particular focus for them for health equity reasons.

(Carrie Al Young): Thank you. This question might be appropriate for Washington. Could you speak on ways based on your experience to successfully integrate national commercial payers into the alignment process, based on your experience?

Laura Pennington: Well as we developed our original common measure set -- and as we continued to evolve it -- we always have an eye to the national measure set. That's one of our core criteria.

And as we do our - go through or QMMI process as well, we're always looking at our scorecard - the CMS scorecard. We're looking at the MIPS measures. We continue to look at all the HEDIS measures. So always keeping, you know, our eye out for what's going on at the national level, understanding that, you know, the plan and the providers also have these other requirements.

So that's one thing that is just at our core as we look for new measures. So that's step number one, what's going on at the national level with this measure? We don't always align, but that's definitely step number one.

Did that answer your question?

(Carrie Al Young): I think that does. Thank you and it looks like we're approaching the end of our event time. So I think we'll wrap up the Q&A now. If folks do have any follow-up questions, please feel free to send an email to Colin directly at CPlanalp@UMN.edu, or you can contact us at our general

email at SHADAC@UMN.edu, and someone will make sure to follow up with you on those questions.

It was great to have the opportunity today to discuss framework and steps around multipayer quality measure alignment, and to hear about lessons learned from the states undertaking this important step in payment and delivery system reform. We'd like to thank Bonnie, Laura, and J.D. from Washington for sharing their experience and insights, and Jennifer and Greg from CMMI for participating and discussing their knowledge and experience.

And thank you to everyone who attended today. We hope you have a great afternoon.