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Advances in Multi-Payer Alignment: State Approaches to Aligning Performance Metrics across Public and Private Payers

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Foreword

The financing of medical care services in the United States is not set up as a market where individual consumers can buy what they think they need. Instead purchasers — employers and the government — and insurers act as intermediaries, buying on our behalf, protecting us from bankruptcy, and helping to ensure adequate access to health care regardless of ability to pay.

This multi-payer system sends mixed or nonexistent signals to providers in terms of guiding the quality of services they provide. Different purchasers and insurers define medical care quality in different ways, due to both the technical challenges involved and the absence of a clear defining authority. No wonder we pay more for medical care in the United States and get poorer population health.

Given the reality of this multi-payer system, how can common standards of provider quality and value be developed so system improvement can accelerate? This Issue Brief explores attempts by locally based public/private groups to take on this challenge. The development of locally supported standards and community norms—for both quality and payment—is important if population health is to improve. Perhaps even more important than what was decided in these community groups was how it was decided. The skills of collaboration, evidence gathering, and consensus promotion are invaluable in all types of health improvement efforts.

The Milbank Memorial Fund believes the lessons outlined here are instructive for others taking on this important work. We salute the groups in Maine, Vermont, and Wisconsin whose efforts are documented here and thank our colleagues at the Center for Health Care Strategies for providing this analysis.

Christopher F. Koller, President of the Milbank Memorial Fund

As Medicaid agencies evolve at varying rates from "bill payer" to "sophisticated purchaser," the importance of performance measurement has increased exponentially. With the proliferation of managed delivery systems of care within Medicaid, states have used increasingly advanced mechanisms to measure access, efficiency, and quality for beneficiaries. Most Medicaid agencies now rely on well-defined performance measures to provide a barometer for program performance and, increasingly, program accountability. To increase their leverage with providers and drive the market toward increased quality and value in a more deliberate way, state Medicaid agencies are exploring opportunities to align with other purchasers (e.g., state employee purchasers, commercial payers) in their states. Some states are using funding from the Center for Medicare & Medicaid Innovation (the Innovation Center) through the State Innovation Models (SIM) Initiative to pursue alignment opportunities.[i]

Payers can align on several different fronts, including payment policies and methodologies,

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quality measurement, administrative practices, evidence assessments for benefit decisions, and data-sharing practices. This paper focuses on quality measurement alignment because of its potential to improve delivery system performance, with less effort and fewer regulatory issues than are involved in aligning payment practices.

Multi-payer collaboration around measurement is very valuable to providers. Typically, providers contract not only with Medicaid and Medicaid health plans, but also with health plans serving other populations, including commercial and Medicare consumers. Often each health plan has its own measurement approach, and providers must juggle a sometimes confusing variety of metrics. A 2013 *Health Affairs* study examined 23 health plans' performance measure sets, identifying 546 distinct measures and widespread variation in both private and public programs.[ii] A separate 2013 analysis of 48 state and regional measure sets found only 20 percent of measures were used by more than one program.[iii] There is also a proliferation of organizations certifying performance metrics, some of which overlap in purview, but have different specifications.[iv] As a result, providers must respond to multiple distinct data requests and program requirements, collecting and reporting often hundreds of different partially overlapping metrics. This creates significant financial, administrative, and resource burdens for providers. Since the percentage of a provider's panel in each payer initiative is likely small, this measurement chaos greatly limits the business case for providers to improve specific performance outcomes.

What is value in health care?

Value can be defined as higher quality health care at lower cost. Put simply, quality health care can be defined as the right care, at the right time, in the right setting.

When multiple payers and plans align their measurement and quality improvement goals, they send a stronger message to providers about what needs to be done, and make it easier for providers to focus improvement efforts and target staff resources effectively.[v] For payers, this means investments in programs like pay-for-performance, patient-centered medical homes, and performance transparency are more likely to produce meaningful results and improvements.[vi,vii]

This Issue Brief addresses recent approaches to aligning provider performance measures across payers, highlighting three state innovators: Wisconsin, Vermont, and Maine. The discussion focuses on hospital and physician group performance measurement, including measures addressing quality, patient satisfaction, and utilization/efficiency. The case studies describe the types of public-private collaborations used to create alignment, the consensus-building process, and keys to success. A discussion of early lessons, key decisions, and outstanding issues follows these descriptions.

CASE STUDY: WISCONSIN STATEWIDE VALUE COMMITTEE

The Statewide Value Committee (SVC) in Wisconsin is seeking to align ambulatory and hospital performance measures, including quality, patient satisfaction, and efficiency measures, across

public and private payers in the state. The SVC was established in November 2011 through the state Medicaid agency and the Thedacare Center for Healthcare Value, driven in large part through a statewide focus on quality improvement and performance measurement.

The SVC goals are to improve purchaser value by: (1) developing clear expectations for value; (2) establishing an agreed-upon set of measures of value across all stakeholders; (3) rewarding providers to improve health, not manage sickness; and (4) publicly reporting measures. Following the development and adoption of a common measurement set, the SVC will focus on identifying, defining, and promoting payment and delivery reform initiatives designed to improve the value of health care. Wisconsin has focused for many years on cross-payer quality initiatives and alignment of measures; SVC promotes the development of new payment and quality initiatives.

The SVC includes more than 35 representatives from private employers, Medicaid and other state purchasers, the provider community, health plans, and consumers. Any interested and relevant group may join. Participants include the Wisconsin Medical Association, the Wisconsin Hospital Association, and individual provider practices. The SVC also includes the Wisconsin Collaborative for Health Care Quality, which was established about 10 years ago to report on health measures with the goal of encouraging providers to improve care, and the Wisconsin Health Information Organization, which established an all-payer database to collect statewide claims information and provide a rich source of data for health analytics.

Step-by-Step Guide to Measure Alignment — Wisconsin

1. Identify and define your health care value opportunity.
2. Know your state's current definition of health care value.
3. Know current definitions of health care value for all relevant stakeholders.
4. Create multi-stakeholder consensus on a set of health care value measures.
5. Reach multi-stakeholder consensus on a set of health care value measures.
6. Understand current flow of value measures data across multiple stakeholders.
7. Align multi-stakeholder data infrastructure to allow for consumer public reporting via a web portal and for provider quality improvement efforts.
8. Establish governance structure to ensure value measures are used, reviewed, and refined.

Source: "The Wisconsin Story," a presentation by Brett David, Medicaid Director, Wisconsin Department of Health Services, January 14, 2014

The SVC uses a Leadership Council to provide direction and make decisions. It consists of 15 voting members representing a range of health care stakeholders and is chaired by John Toussaint, CEO of Thedacare Center for Healthcare Value. A Measurement Advisory Committee reports to the Leadership Council. The SVC is staffed jointly by the Wisconsin Department of Health Services and the Thedacare Center for Healthcare Value.

Measure Selection and Use: Wisconsin started with 200 measures already used in quality improvement efforts throughout the state. At the end of an 18-month selection process, the SVC identified a condensed set of 14 ambulatory- and hospital-level measures. Approval by the

Leadership Council is pending for an additional three measures. While a Measurement Advisory Committee is responsible for developing and proposing the aligned measure set, the Leadership Council is responsible for the final determination of the measure set. Several types of individuals were essential to Wisconsin's success: (1) a committed state-level leader, in this case the state Medicaid director; (2) a trusted neutral consensus builder; and (3) a strong program manager to staff the committee.

Each member of the SVC can endorse, adopt, or operationalize the measure set at their discretion. The committee is now focusing on developing a baseline for the endorsed measures, along with specifications for public reporting. The SVC will then define on a practical level what it means for payers to "adopt" or "operationalize" metrics within the context of public reporting and value-based contracts. Payers are not necessarily constrained to using only these measures. But to the extent that they want to measure a condition covered by the aligned set, for example, diabetes, payers generally agree to use the agreed-upon specifications, without committing to a specific implementation timeline.

Future Plans and Opportunities: Going forward, the SVC will seek to manage its priorities to avoid overwhelming providers and other stakeholders. Particular areas of attention include:

- *Infrastructure Development*: A focus on building the best infrastructure to support providers and analyze data across payers. As electronic medical records and health information exchanges mature, there will be new data available to stakeholders, such as clinical and lab data to allow calculation of additional measures. It will be important to develop a statewide strategy for using this technology effectively to further alignment and quality improvement.
- *Goal Setting*: Official goals for the overall SVC and for individual stakeholders participating in the group will need to be established.
- *Public Reporting:* The SVC will need to support continued public reporting at the practice and hospital level to disseminate its work and enable consumers to make more educated health care decisions.
- *Health Plan Contracting:* The state can explore a variety of options to incorporate the SVC measures into Medicaid health plan contracts.
- *Revising Measures*: The alignment of measures across payers is a moving target and should be revisited on an ongoing basis. As more is learned around clinical care and what measurement and payment strategies drive value, the SVC will update its measures.

CASE STUDY: VERMONT

The goal of Vermont's Quality and Performance Measures Workgroup, which is part of the state's SIM initiative, is to measure the impact of delivery system and payment reform efforts. The

workgroup is seeking to align different measurement activities across the state, starting with the commercial and Medicaid accountable care organization (ACO) programs.

A multi-stakeholder, public-private predecessor workgroup (the ACO Measures Workgroup) was established in December 2012 to develop the quality measurement standards for the commercial and Medicaid Shared Savings Programs. In November 2013, the workgroup was renamed the Quality and Performance Measures Workgroup, and was charged with developing quality and performance measurement strategies for additional delivery system and payment reform efforts in the state. A broad group of stakeholders participate as workgroup members, including representatives from provider organizations, ACOs, state agencies (e.g., the Agency of Human Services, the Department of Vermont Health Access [Medicaid], and the Green Mountain Care Board), commercial payers, and consumer advocacy organizations. The group meets monthly to discuss quality measurement activities related to delivery system and payment reform efforts. The Green Mountain Care Board, which oversees commercial payers, and the state Medicaid agency serve as the lead organizations in this effort, using their SIM funding to assist with administration. Vermont has long focused on public-private partnerships to promote quality health care in the state through initiatives led by state government and by the Vermont Program for Quality in Health Care, which was founded in 1988 by a coalition of health care providers, payers, employers, and consumers.

Measure Selection and Use: In launching the Quality and Performance Measures Workgroup, Vermont prioritized the need for stakeholder engagement. The workgroup invited stakeholders to propose measures for use in the commercial and Medicaid ACO Shared Savings Programs, with the initial measure set totaling more than 200 items. From that initial list, the workgroup identified an agreed-upon set of quality priorities and criteria for selecting measures. Examples of selection criteria included: (1) endorsement by the National Quality Forum or other national groups; (2) alignment with existing federal and state quality programs (e.g., the Medicare Shared Savings Program); and (3) ease of data collection. Each measure was reviewed against these (and other) criteria individually. From the initial set of 200 measures, the workgroup narrowed the list down to approximately 30 measures and will revisit these measures on an annual basis. All of the measures are endorsed by a national quality group (e.g., patient experience measures from the CAHPS tool), rather than being "home-grown" measures. After the measure set was endorsed by a majority of the workgroup members, it was considered by the SIM Steering Committee (a broad-based stakeholder group), and ultimately approved by the Core Team (the SIM governing body) and the Green Mountain Care Board.

Of the approximately 30 measures selected by the workgroup, there is almost complete overlap between those to be used for the Medicaid and for the commercial ACO programs. There is one measure that had data collection barriers in the commercial population (developmental screening for children); Medicaid will use this measure in its shared savings program, but the commercial payers will not in Year 1.

Future Plans and Opportunities: The Vermont workgroup is reviewing the ACO measures for 2015 and will focus on continued alignment of measures across new programs, particularly those developed under SIM. In considering future measures, the workgroup will review measures suggested by stakeholders as well as those measures used in other programs by purchasers in the state. In the future, the group will also develop measure sets for the state's Episodes of Care and Pay-for-Performance initiatives.

Vermont has a history of publicly reporting quality information and has reported health plan- and hospital-specific information for many years. The state anticipates that the Quality and Performance Measures Workgroup and other SIM workgroups will review results from the ACO Shared Savings Program and other SIM payment reforms. In addition, the state suggested that more formal reporting mechanisms might be developed.

CASE STUDY: MAINE

MaineCare, the state's Medicaid program, has an ongoing and successful collaboration with its regional health improvement collaborative (RHIC), composed of two entities: Maine Quality Counts and Maine Health Management Coalition. These three entities work together to convene consumers, providers, purchasers, payers, and public health organizations to improve the quality and cost of health care in the state. The collaboration includes: (1) collecting, measuring, and public reporting of quality data; (2) conducting quality improvement initiatives and support for providers; (3) helping consumers become more actively involved in their health care; and (4) driving delivery system and payment reform throughout the state. The partners have also worked closely on value-based purchasing strategies, such as the design and implementation of patient-centered medical homes, health homes, and accountable care communities.

Measurement Selection: Maine's SIM initiative spans several multi-payer care delivery, payment reform, and consumer engagement efforts. The purpose of the measurement alignment activity is to develop a core set of targeted measures to monitor statewide progress across all SIM efforts in achieving the Triple Aim goals of improved health outcomes, improved patient experience, and lower costs. Working within the SIM governance structure, which includes representation across providers, payers, and consumers, the state has convened a SIM Core Metric Team to undertake this work. In preparation, the state created a crosswalk of performance measures used in Maine's various quality and cost improvement initiatives, including patient-centered medical home, health homes, and Accountable Communities. The SIM Core Metric Team then mapped those metrics to the Maine SIM Strategic Pillars, which reflect the overall strategic aims of Maine's SIM initiative, with a goal of developing a measure set that cuts across all these pillars. Similar to Wisconsin and Vermont, the metrics team developed a set of criteria that its core SIM measures must meet and is using those to guide its measure selection process. These criteria include:

- Align across multiple model measure sets;
- Align with SIM strategic pillars and Triple Aim goals;
- Reflect a mix of process and outcomes and short- and long-term impacts;
- Address populations prevalent in Medicaid (children, behavioral health, disabilities);
- Safeguard against restrictive patient/client selection practices (i.e., cherry picking and premature discharge of patients); and
- Address the Innovation Center's core measurement areas related to population health (diabetes, obesity, and tobacco control).

Based on these criteria, the state identified several high priority measurement domains for tracking the overall performance of its SIM activities, including emergency department utilization, hospital readmissions, imaging, care coordination, mental health, pediatrics, patient experience, obesity, and diabetes care. The next step will be for Maine's SIM Core Metric Team to select a set of 10-15 core metrics based on the mapping work to date. This measure set will be submitted to the SIM steering committee for final approval this summer. While Maine will need to determine the data sources and metric development regarding the SIM Core Metrics, its all-payer claims database will be the primary source.

LESSONS LEARNED

Following are key takeaways from the three states detailed above to help guide additional states in achieving consensus on an aligned performance measurement strategy:

1. Commit to incorporating six elements that are key to success:

   - **Prominent state leadership**. Establishing high-level state government leadership and support is key to getting payers to the table and committed to the alignment process.
   - **Multi-stakeholder governance**. Developing a multi-stakeholder governance structure that promotes informed decision-making is critical. A steering committee made up of diverse stakeholder leaders representing state purchasers, health plans, providers, and consumers will be essential to making the tough choices.
   - **Use of neutral convener**. The convener(s) plays an important role in helping the partnership set goals, provide the overall framework for the effort, organize the partnership, and spread and sustain best practices.
   - **Use of trusted facilitator**. Selecting a trusted facilitator is critical to creating buy-in around difficult decisions. The facilitator needs to have a high level of trust, a reputation for being an honest broker, and the ability to develop consensus.
   - **Access to technical information**. Solid technical information is critical to informed decision-making, but must be balanced against other stakeholder priorities.

- **Project management support**. Efficient project management is essential for moving the process along efficiently.

2. Involve a diverse set of stakeholders throughout the process:

   - Providers are essential partners that states should engage early on to design and implement a successful measurement alignment strategy; and
   - Large employers in the state, health plans (both those serving Medicaid and commercial populations), consumer representatives, and Regional Health Improvement Collaboratives (RHICs) in the state should also be included.

3. Develop up-front consensus among stakeholders on three key decisions that will be instrumental in guiding the process to completion and selecting an appropriate set of metrics:

   - The purpose of an aligned metrics set (e.g., provider performance feedback, public reporting to inform consumer decision-making, value-based payment, evaluation of system-wide performance);
   - The provider entities to be measured (hospitals, ACOs, individual physicians); and
   - A set of criteria to guide the selection process and help facilitate agreement among partners with varying, and at times, conflicting goals and priorities.

4. Determine the relationship of measurement alignment efforts to payment reform efforts — they can be tightly linked to specific payment efforts, as in the Vermont ACO example; or established and linked at a higher strategic level, as in Wisconsin and Maine.

5. Building in sufficient time is key — many alignment efforts took at least 12 months.

COMMON ISSUES FOR STATE CONSIDERATION IN MEASUREMENT ALIGNMENT

Wisconsin, Vermont, and Maine provide strong examples around aligning measurement strategies for state health care stakeholders to consider. In pursuing alignment, states must confront a common set of issues along the way. Among the states profiled in this brief, many are still grappling with these challenges.

- ***Adopting the appropriate number of measures.*** It is important to consider the administrative work associated with data collection and data analytics for each measure. Furthermore, it can be difficult for providers to focus on too many quality improvement initiatives at one time, which may dilute improvement efforts and overall results. Selection criteria might include a balanced portfolio of metrics across quality, patient satisfaction,

and efficiency, as well as across different patient populations, such as kids and adults. Partnerships might consider "retiring" measures that have achieved a threshold for improvement or bundling a set of measures that relate to a particular disease.

- ***Using national measures vs. state-specific measures.*** In adopting measures, partnerships may create "home-grown" measures or adopt national, standardized measures from a quality organization, such as HEDIS or CAHPS. While national measures may not be perfect for every state or may not address populations with complex care needs (e.g., long-term services and supports or mental health and substance abuse screening and treatment), they do offer a benchmark for comparison. Partnerships may need to consider a balance of homegrown and standardized measures to ensure meaningful results with minimal administrative burden.
- ***Defining alignment.*** As partnerships select a common set of measures, they will also need to establish a strategy for data collection and measurement calculation. At one end of the spectrum, a central entity collects data and calculates the metrics, while at the other end, each payer is solely responsible for collecting and reporting its metrics. If the state has an all-payer claims database (APCD), it may be possible for one entity to calculate measures across all partners and for each payer individually, if appropriate. In the absence of an APCD, each partner likely will calculate measures on their own and submit results for partnership-wide reporting. Additionally, stakeholders will need to consider how and whether to reconcile different risk adjustment methods that payers may use depending upon the patient population.
- ***Including national insurance companies.*** In states that use national insurers to provide coverage for commercial, Medicaid, and Medicare populations, many of these insurers have excellent data analytic tools and support the goals of measurement alignment. However, it may be costly for these insurers to adopt alternative measures specific to different states. States may need to develop creative ways for national stakeholders to participate in a standardized way.
- ***Incorporating increasingly sophisticated health information technology.*** As electronic medical records become more mainstream and health information exchanges more sophisticated, measurement partnerships will have significantly greater opportunity to collect meaningful clinical data. As this technology evolves, partnerships can plan for ways to benefit from these advances and revisit measures in the future.
- ***Educating consumers in measurement science "101".*** Consumers and consumer advocates often play a key role in measurement partnerships and offer an invaluable perspective on which measures will be meaningful to consumers in making educated decisions about health care. The partnership can play a role in educating consumers about: (1) measurement, such as what measures are reasonable to collect; (2) clinical data, such as what are and are not available; and (3) an appropriate balance between short- and long-term measures.

CONCLUSION

Aligning performance measurement across payers offers great opportunity for states to encourage improvement among providers and improve the health of their citizens, regardless of source of insurance coverage. The alignment process takes a significant amount of time, consensus building, and dedication of all partners. However, the partnerships and trust built through this process can serve as a solid foundation for moving ahead on other key areas on multi-payer alignment, including data collection, public reporting, program what participation requirements, and advanced payment methodologies.

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ENDNOTES

i. The State Innovation Models Initiative is providing up to $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad-based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program.

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