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# Provider Performance Measures In Private And Public Programs: Achieving Meaningful Alignment With Flexibility To Innovate

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**ABSTRACT** In recent years there has been a significant expansion in the use of provider performance measures for quality improvement, payment, and public reporting. Using data from a survey of health plans, we characterize the use of such performance measures by private payers. We also compare the use of these measures among selected private and public programs. We studied twenty-three health plans with 121 million commercial enrollees—66 percent of the national commercial enrollment. The health plans reported using 546 distinct performance measures. There was much variation in the use of performance measures in both private and public payment and care delivery programs, despite common areas of focus that included cardiovascular conditions, diabetes, and preventive services. We conclude that policy makers and stakeholders who seek less variability in the use of performance measures to increase consistency should balance this goal with the need for flexibility to meet the needs of specific populations and promote innovation.

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**D**uring the past two decades there has been substantial growth in the availability and use of performance measures. The National Quality Forum, a nonprofit organization that establishes consensus standards for measuring performance, has endorsed more than 700 measures.<sup>1</sup> The use of provider performance measures for quality improvement, pay-for-performance, and public reporting purposes has become commonplace.

Performance measures increasingly play an integral role in assessing the achievement of high-quality, efficient care in new health plan and Medicare payment and delivery models such as accountable care organizations, patient-centered medical homes, and bundled and global payment.<sup>2,3</sup> Understanding performance measures and their use is vital to ensuring the availability of reliable performance information.<sup>4</sup>

Information on measures that are used to assess providers' performance in Medicare is

publicly available through the federal rule-making process. In contrast, we are aware of only a few reports that examine the use of performance measures in the private sector. The primary focus of these reports has been the use of measures endorsed by the National Quality Forum across a cross section of users, including community collaboratives, accrediting organizations, a few health plans, and the public sector.<sup>1,5</sup> The National Quality Forum also has catalogued the performance measures used by the Aligning Forces for Quality communities.<sup>6</sup>

This existing body of work provides only a limited understanding of the measures used by health plans to assess providers' performance. Consequently, little is known about how performance measures used by health plans compare with those used in public- and other private-sector programs.

To address this gap in knowledge, we conducted a study with the primary purpose of gaining a better understanding of health plans'

use of provider performance measures in payment and delivery system models. Using the data collected from our study, we also compared the use of performance measures by health plans and the use of measures by Medicare fee-for-service and community-based programs—namely, the Aligning Forces for Quality communities.

Our analysis will be useful to payers, providers, policy makers, and other health care stakeholders for two primary reasons. First, a descriptive analysis of health plans' use of performance measures, especially in the context of new payment and delivery models, will help other health plans, Medicare, and providers that are entering into new payment contracts that include a performance assessment component. Second, a comparative analysis of performance measures used by health plans versus those used by other programs, both private and public, can help inform ongoing efforts to “align” such measures across programs. Despite the National Quality Forum's work to harmonize performance measures where appropriate, there is an ongoing debate about the degree of variability in the use of performance measures and the need to address such variability by bringing the measures into closer alignment.

The Measure Applications Partnership, Buying Value, and the Centers for Medicare and Medicaid Services (CMS) are implementing efforts to align performance measures across federal programs and between public and private programs.<sup>7-10</sup> All of these different efforts would benefit from a better understanding of how health plans are using performance measures.

### Study Data And Methods

**SAMPLE** We drew a purposive sample of twenty-nine health plans that were members of America's Health Insurance Plans and that had a commercial insurance plan as their main product. Our goal in constructing the sample was to select plans that account for the majority of commercial enrollees while at the same time ensuring the inclusion of plans with different sizes and geographic areas of operation.

The twenty-nine plans in our sample covered 133 million commercial enrollees. Twenty-three plans with 121 million commercial enrollees (66 percent of the national commercial enrollment, based on the Atlantic Information Service's 2011 health plan directory<sup>11</sup>) submitted data for our study. The online Appendix shows the sampling distribution of health plans by enrollment and census region.<sup>12</sup>

We consider the study data to be a valid source of information on performance measurement. The plans in the sample were not randomly se-

lected. However, the distribution of the plans in the study by size and geography, coupled with their high share of enrollment, means that the findings should be reasonably representative of the nation's commercial insurance market. Two out of three commercial enrollees in the United States are members of plans that submitted data for our study.

**DATA COLLECTION** We conducted a review of publicly available documents and materials from health plan websites and regional quality collaboratives to catalog performance measures used by the sample plans. To account for the possibility that health plans might have assigned different names to the same measures, we mapped the measures collected from these sources to standard performance measure names, using the National Quality Forum's Quality Positioning System database and the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measure sets.<sup>13,14</sup> For example, “mammography rate” was mapped to the standard HEDIS measure “breast cancer screening.”

We created a standard template for each health plan that included specific data elements such as measure name, measure developer, measure use by program type (accountable care organization, patient-centered medical home, pay-for-performance, bundled or episode-of-care payment, comprehensive or global payment, and high-performance networks or tiering programs). The template also included an indication of whether the measure was currently in use or planned for future implementation. In high-performance networks or tiering programs, health plans classify providers based on their performance on quality and cost measures and make this information available to their members. The goal is to encourage patients to select high-quality providers.<sup>15</sup>

The standard template containing health plan-specific data was sent to the chief medical officers of the sample plans for verification and revisions. We collected data between November 2011 and May 2012.

**DATA ANALYSIS** We entered the data verified by the plans into a Microsoft Access database for analysis. In addition to capturing the data elements described above, we also categorized measures by domain, subdomain, and type. Measure domains and subdomains are commonly used to group measures that “are related to one another because they address a similar aspect of the quality or performance of health systems.”<sup>16</sup> The difference between domains and subdomains in our analysis was determined by scope. For example, the domain “management of acute and chronic conditions” included performance measures for

several clinical conditions, while its subdomains included measures for specific conditions such as diabetes and cardiovascular conditions.

We also defined domains and subdomains for crosscutting measures—those that are not specific to one condition or setting of care. Care coordination activities, such as medication reconciliation, can affect patient safety. Therefore, measures pertaining to care coordination and patient safety are typically combined in a single crosscutting domain, as is done in the Medicare Shared Savings Program.<sup>17</sup> We also used two distinct subdomains—care coordination or transitions and patient safety—to further analyze measures unique to each area. Finally, to group measures by type, we relied on the well-established Donabedian framework of structure, process, and outcome. Again, this type of analysis is common in the literature.<sup>5,18</sup>

We categorized the measures into nine domains; thirty-eight subdomains, for clinical conditions or crosscutting areas; and seven types, discussed below. We then conducted a descriptive analysis of the data using those categories and a comparative analysis of the use of performance measures by health plans and other private- and public-sector programs.

**LIMITATIONS** We analyzed the performance measurement practices of plans that account for the majority of commercial enrollees. However, our data were limited to the responses of twenty-three plans and had a bias toward large plans. Our findings cannot be generalized to different types of plans, especially medium-size and small plans.

In addition, we did not inquire into such matters as the plans' use of standard measure specifications, the scope of various payment and delivery models (for example, we did not ask if performance measures were used across multiple providers or in pilot programs of limited scope), the rationale for selecting the measures used, and challenges in implementation of the measures. We view our study as an initial foray into the use of performance measurement in payment and delivery models, and we recognize the need for additional research to gain an understanding of these important factors.

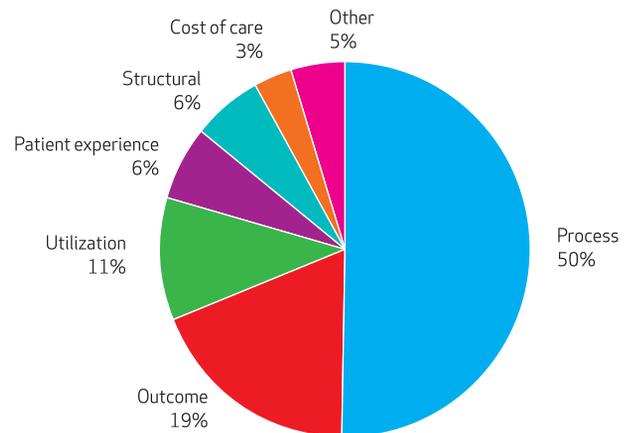
## Study Results

**TYPES OF MEASURES** The health plans in our study reported using 546 distinct measures (individual and composite). Process, outcome, and utilization measures accounted for 80 percent of the performance measures used (Exhibit 1).

The National Quality Forum defines a *composite measure* as “a combination of two or

### EXHIBIT 1

Health Plans' Use Of Performance Measures, By Type Of Measure



**SOURCE** Authors' analysis. **NOTES** The study included twenty-three plans. "Other" includes access to care and physician experience.

more individual measures in a single measure that results in a single score.<sup>19</sup> Using this definition, we identified twenty-seven composite performance measures reported by twenty-one plans. The Agency for Healthcare Research and Quality's patient safety indicator, with eleven component performance measures, is an example of a composite measure.<sup>20</sup> The health plans in our study used composite measures in the areas of patient experience, cardiovascular conditions, diabetes, preventive services or screenings, surgical care, and patient safety.

**DOMAINS AND SUBDOMAINS** Exhibit 2 shows the distribution of performance measures in domains and subdomains used by at least half of the responding plans. In terms of specific clinical conditions, health plans focused their performance measurement on a few high-prevalence or high-cost conditions such as diabetes, cardiovascular conditions, and asthma.<sup>21</sup>

Almost all of the domains and subdomains in Exhibit 2 ranked high, in terms of both the number of measures they contained and the number of plans implementing these measures. There were two exceptions: The subdomain of upper respiratory illness had only four measures but was used by eighteen of the twenty-three plans, and surgical care included thirty measures but was used by only seven plans (and thus is not shown in the exhibit). In general, we found little use of measures for specialty care.

**VARIABILITY** To characterize variability in measure use, we first categorized the performance measures by measure concept and determined whether or not individual measures were related to the same or different concepts. We use the term *measure concept* to describe an out-

## EXHIBIT 2

## Performance Measurement Domains And Subdomains Commonly Used By Health Plans

Domains and subdomains	Plans using domain or subdomain	Distinct measures in domain or subdomain
<b>DOMAINS</b>		
Management of acute and chronic conditions	22	276
Care coordination or patient safety	22	86
Preventive services or screenings	21	41
Cost of care or resource use	20	69
Patient experience	18	34
Structural capabilities	11	32
<b>SUBDOMAINS</b>		
Care coordination or transitions	22	31
Cardiovascular conditions	21	80
Diabetes	21	36
Asthma	19	20
Patient safety	18	55
Mental health and substance abuse	18	16
Upper respiratory illness	18	4
Pulmonary conditions	17	19
Health information technology	11	29
Hypertension	11	2

**SOURCE** Authors' analysis. **NOTES** The study included twenty-three plans. At least half of them reported using the domains and subdomains shown.

come or process in health care that can be assessed but that does not include detailed specifications for calculating the measure.<sup>22</sup> In contrast to a concept, a measure is very specific and includes clear definitions of numerator and denominator populations, diagnosis codes, and exclusions. For example, in our study, inpatient utilization is a measure concept that can be measured in different ways, including hospital admissions per thousand health plan members and inpatient length-of-stay.

We mapped the measures to measure concepts for two high-prevalence clinical conditions (the subdomains of cardiovascular conditions and diabetes) and two nonclinical domains with the most measures (cost of care or resource use and patient experience). For example, individual measures such as blood pressure control of < 130/80 mm Hg and blood pressure control of < 140/90 mm Hg were mapped to the measure concept "blood pressure control for diabetes."

We observed different patterns of variability in the use of measures in these clinical conditions and domains. In the domains of cost of care or resource use and patient experience, we found that most of the measures mapped to a few measure concepts. Sixty-five of the sixty-nine measures in cost of care or resource use mapped to seven measure concepts, and twenty-three of thirty-four patient experience measures were variations of just three measure concepts.

In the domain of cardiovascular conditions,

however, we found that a greater number of measure concepts were being assessed, with fifty of the eighty measures being variations of fifteen measure concepts. These concepts included the provision of therapies such as angiotensin-converting enzyme inhibitors, antitensin receptor blockers, or antithrombotics; mortality rate for cardiovascular conditions; and hospital readmissions. The concepts also included measuring the quality of care for patients with acute myocardial infarction or congestive heart failure. This variation in measure use occurs because cardiovascular disease is a range of conditions instead of a single one.

**INDIVIDUAL MEASURES** In addition to examining health plans' use of performance measures by domains and subdomains, we also sought to identify the measures used by more than half of the plans in our study. There were twenty-six measures in that category (Exhibit 3), and all but two of them were HEDIS measures. No measures for emergency department care or use of generic medications are in HEDIS or have been endorsed by the National Quality Forum.

**PAYMENT AND CARE DELIVERY MODELS** We compared the use of performance measures across different payment and delivery models to identify similarities and differences. Such an analysis can help inform payers' choice of performance measures when implementing these models.

The performance measures used in accountable care organizations, patient-centered medical homes, pay-for-performance, and high-performance network or tiering programs focused on cardiovascular conditions, diabetes, preventive services, and patient safety. We observed greater use of cost-of-care and resource-use measures in accountable care organizations and patient-centered medical homes than in high-performance or tiering programs. Approximately three-quarters of the performance measures used in high-performance networks or tiering programs were process measures. In comparison, process measures constituted approximately half of all performance measures used by accountable care organizations and patient-centered medical homes and 55 percent of those used in pay-for-performance programs.

**COMPARING PRIVATE AND PUBLIC PROGRAMS** As described above, a comparative analysis of the use of performance measures across public and private programs can help inform ongoing efforts to achieve measure "alignment." Our approach to this analysis involved examining similarities and differences in the use of measures along the following dimensions: measure domains and subdomains and individual measures. For the last dimension, we compared the use of

**EXHIBIT 3**
**Performance Measures Commonly Used By Health Plans, By Domain Or Subdomain**

Measure	Plans using measure	Developer or steward of measure
<b>DIABETES</b>		
LDL control (< 100 mg/dL)	19	HEDIS
Nephropathy screening	18	HEDIS
HbA1c testing	17	HEDIS
Eye exams	17	HEDIS
LDL screening	17	HEDIS
Poor glycemic control (HbA1c > 9%)	14	HEDIS
Blood pressure control (< 140/90 mmHg)	13	HEDIS
HbA1c control (<7%)	13	HEDIS
<b>CARDIOVASCULAR CONDITIONS</b>		
LDL control (< 100 mg/dL)	19	HEDIS
LDL screening	12	HEDIS
Persistence of beta-blocker treatment after heart attack	12	HEDIS
<b>ASTHMA</b>		
Use of appropriate medications	17	HEDIS
<b>PULMONARY CONDITIONS</b>		
Avoidance of antibiotic treatment in adults with acute bronchitis	14	HEDIS
<b>CARE COORDINATION OR PATIENT SAFETY</b>		
Annual monitoring for patients on persistent medications	14	HEDIS
Plan all-cause readmissions	14	HEDIS
ED visits	13	Internally developed
<b>PREVENTIVE SERVICES OR SCREENINGS</b>		
Breast cancer screening	21	HEDIS
Cervical cancer screening	20	HEDIS
Colorectal cancer screening	18	HEDIS
Chlamydia screening (women)	16	HEDIS
Childhood immunizations	16	HEDIS
Well-child visits	13	HEDIS
<b>COST OF CARE OR RESOURCE USE</b>		
Imaging studies for lower back pain	15	HEDIS
Use rate of generic drugs	12	Internally developed
<b>UPPER RESPIRATORY ILLNESS</b>		
Appropriate testing of children with pharyngitis	16	HEDIS
Appropriate treatment for children with upper respiratory infection	14	HEDIS

**SOURCE** Authors' analysis. **NOTES** The study included twenty-three plans. At least half of them reported using the measures shown. LDL is low-density lipoprotein cholesterol. HEDIS is Healthcare Effectiveness Data and Information Set. HbA1c is hemoglobin A1c. ED is emergency department.

identical measures to that of similar measures—that is, those that were tied to a single measure concept such as hemoglobin A1c control.

For a comparative analysis with other ongoing private-sector performance measurement efforts, we used data published in the National Quality Forum's Community Tool to Align Measurement. This tool reports performance measures used by the Aligning Forces for Quality communities.<sup>6</sup> We focused on the use of performance measures by these communities for the following reasons: Measures used by them are publicly available; they have experience with performance measurement and reporting; and many of them are also part of state-mandated

reporting efforts, such as one in Minnesota,<sup>23,24</sup> or are Chartered Value Exchanges. Designated by the Department of Health and Human Services, Chartered Value Exchanges are regional multistakeholder collaboratives that publicly report quality information, promote incentives for improving the quality and efficiency of care, and advance the use of interoperable health information technology.<sup>25</sup>

The Community Tool to Align Measurement lists 171 performance measures in use across the sixteen Aligning Forces for Quality communities. More than 60 percent of these measures assess hospital performance, but only fifty of the hospital measures were also reported

on CMS's Hospital Compare website.<sup>26</sup> Only 19 of the 171 performance measures were used by more than half of the communities.

Our comparative analysis revealed that the health plans in our study and the Aligning Forces for Quality communities focused on similar measure domains and subdomains. These included prevention (cancer screenings, immunizations, and well-child visits), diabetes, cardiovascular conditions, asthma, and patient safety.

Comparisons of the individual performance measures used by a majority of health plans (Exhibit 3) with the measures used by a majority of the Aligning Forces for Quality communities, however, yielded little overlap. Only eight performance measures in Exhibit 3 were also used by a majority of the Aligning Forces for Quality communities. These eight measures pertained to diabetes, breast and cervical cancer screening, and the use of appropriate medications for people with asthma.

Next we analyzed similarities and differences between our study data and the performance measures used in the Medicare Shared Savings Program<sup>17</sup> and the Physician Quality Reporting System.<sup>27</sup> The Medicare Shared Savings Program makes participating providers responsible for care management for assigned patient populations and shares savings with providers if they meet specific quality and cost performance targets. Our analysis used the data in Exhibits 2 and 3 as the basis for comparison.

With respect to the Medicare Shared Savings Program, we found similarities in the domains and subdomains of measures, although overlap at the individual measure level was minimal (Exhibit 4). Only five performance measures were identical, and only three were similar—that is, related to the same measure concept. For example, the Medicare Shared Savings Program

uses hemoglobin A1c control below 8 percent as a measure for patients with diabetes, while most health plans use the HEDIS measure of below 9 percent for poor glycemic control (Exhibit 3).

When we compared 2013 Physician Quality Reporting System measures with the measures in Exhibit 3, we found similar results—that is, concordance at the level of the domain or subdomain but variation in the specific measures used.<sup>28</sup> Seventeen out of 301 performance measures in the Physician Quality Reporting System were identical to measures in Exhibit 3.

## Discussion

Evidence from our study clearly points to widespread variability in which individual performance measures were selected and implemented, in both private and public payment and care delivery programs. Although we did not explore the reasons for the variations we observed, prior work offers some clues. For example, variations may arise from the need for flexibility in payer-provider accountable care partnerships or for the ability to tailor these partnerships to a provider's patient population.<sup>3</sup> Additional factors contributing to variations could include the lack of standardized measures in areas such as the cost of care and specialty care, as well as the lack of common measurement goals.

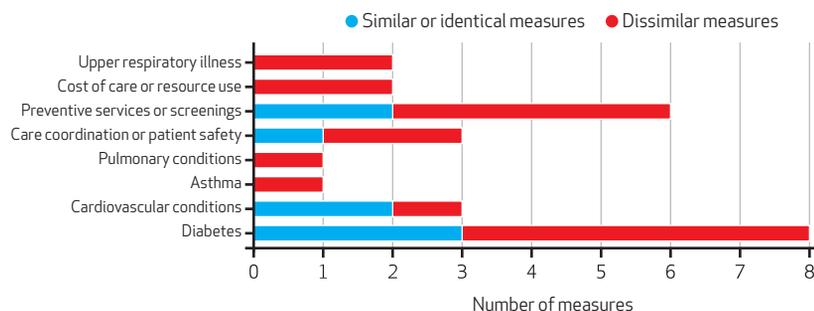
Regardless of its causes, variability in the use of performance measures has been recognized as a source of frustration to both providers and patients.<sup>29</sup> As stated above, stakeholders are working to minimize variability in performance measures and promote “alignment” across public and private programs. One approach in this area has been to identify a common core set of measures that could be adopted universally.<sup>9,30</sup> Other approaches include the retirement of performance measures that have proved to be ineffective in changing behavior or improving quality, which would result in the use of fewer measures and less variability. However, despite the fact that the National Quality Forum has endorsed a plethora of performance measures, little is known about which measures are effective in achieving desired goals.

Instead of presenting different approaches to addressing variability in the use of performance measures, we focus next on specific considerations for stakeholders that are pursuing alignment as a solution to variability, and we offer caveats about addressing measure variability.

**DEFINING AND MONITORING ALIGNMENT** To begin with, stakeholders pursuing measure alignment should agree on a definition of *alignment*.

### EXHIBIT 4

**Performance Measures Used In The Medicare Shared Savings Program And By A Majority Of Health Plans In The Study**



**SOURCE** Authors' analysis. **NOTE** The study included twenty-three plans.

Although there are ongoing discussions of performance measure alignment, we were unable to find any formal definition of this term. *Alignment* should be defined to ensure a common understanding, make it possible to implement a systematic approach to address variability, and ultimately monitor progress over time.

Policy makers need to assess alignment by examining variability or congruence based on the following factors: commonality of program goals; domains and subdomains measured, such as specific clinical conditions; specific measures or measure concepts; settings of care assessed, such as inpatient and outpatient; and longitudinal measurement—across care settings and time—for a given patient, which would ensure cohesiveness in the measures used to assess care as patients seek care within and across settings. Such a multidimensional approach to alignment would help policy makers focus on the most critical aspects of alignment and establish appropriate strategies. It might also provide a rationale for maintaining the status quo in some cases.

**IMPLEMENTATION** In addition, stakeholders working on aligning performance measures need to address two key practical issues related to implementation. First, even if public and private payers agreed to a core set of measures, this set might be different from the measures currently in use. Transitioning to the core set would require careful planning to create provider buy-in and address issues of comparability in performance data over time.

Second, agreement merely on a core set of performance measures would not eliminate variability if there were differences in the specifications for the measures. Our experience with aggregating multipayer data has shown that the structure of claims data used to calculate measures varies across payers and other stakeholders such as community-based programs.<sup>31</sup> Attention needs to be paid to the consistent implementation of measure specifications, to account for differences in underlying data. Possible solutions include the use of uniform rules when implementing measure specifications in conjunction with measure developers. Measure developers should also be able to incorporate such feedback from measure implementers into updates of the measure specifications.

**CAVEATS ON VARIABILITY** Although reducing variability in the use of performance measures across public and private sectors is generally viewed as desirable, certain circumstances may make it inadvisable. For example, variability arising from the need to assess different popu-

lations is well known and widely accepted. Other considerations that warrant variability are described below.

► **MULTIDIMENSIONAL VIEW OF QUALITY:** Our analysis has shown that some of the variation that now exists arises from the need to assess different measure concepts, such as hospital admissions and inpatient lengths-of-stay. This type of variability can lead to more robust measurement of overall quality, and eliminating it would be detrimental to quality measurement.

► **MEASURE INNOVATION:** Measurement science is continually evolving, and there is a need to test different measures in real-world settings to ascertain their effectiveness. For example, the National Quality Forum has endorsed two composite measures for diabetes—optimal diabetes care and comprehensive diabetes care—and there is insufficient evidence to determine which measure is better. Until evidence is forthcoming in this and similar cases, testing different measures is critical to advancing measurement science.

► **PROGRAM TYPE:** Any efforts to reduce variability in measure use across public and private sectors should be based on the type of program in which the measures are being applied. The program's goals should be taken into account, as well as its purpose. For example, is the purpose to improve quality, to report data to the public, or to reform payment?

The use of identical performance measures across public and private payers is more important in the context of public reporting than for other purposes, to ensure the availability of consistent information for consumers. In contrast, measures for internal quality improvement can vary to meet the needs of a provider's patients and quality improvement goals. In related work, we have discussed criteria for achieving harmony in the use of measures for payment purposes.<sup>32</sup>

## Conclusion

Our analysis provides a baseline understanding of the use of performance measures in health plan payment and delivery models and can inform efforts to address variability in the use of such measures. Additional research is needed to better assess gaps in available performance measures, challenges associated with the use of the measures in the field, the availability of data sources for measurement, and the evolution of private-sector performance measurement over time. ■

The views expressed in this article are those of the authors and do not necessarily represent the positions or policies of their employers.

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