

QUALITY MEASUREMENT TO SUPPORT
VALUE-BASED PURCHASING: ALIGNING
FEDERAL AND STATE EFFORTS

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EXECUTIVE SUMMARY

Accurate and reliable quality measurement is increasingly important to federal and state payment strategies. A new generation of technical infrastructure is enabling payers at both levels of government to define and identify high-value service delivery. Recent reforms, including the Affordable Care Act, are pushing payers to become more prudent purchasers of care, spurring them to implement payment strategies that reward value in the health care system. At the same time, a National Quality Strategy and mechanisms to reach consensus on quality metrics are emerging to more precisely define what quality—and thus value—mean in health care.

These efforts are taking a variety of shapes at the federal and the state level. At the federal level, Medicare is becoming a more prudent direct purchaser of health care services through several value-based purchasing initiatives and through programs that are fostering the development of accountable care organizations. States are likewise using provider performance on quality measure sets to affect reimbursements for primary care providers serving as medical homes, for hospitals, and for health plans. Investments in health information technology in states are helping to hold providers accountable for cost and quality outcomes, and to create new tools and portals to help them deliver better care.

In November 2013, the National Academy for State Health Policy (NASHP) convened and facilitated a discussion among high-level federal and state leaders. The meeting: 1) gave state participants the opportunity to learn about and discuss new opportunities and promising practices for measuring quality under value-based purchasing approaches with their peers, 2) gave states the chance to learn about new federal opportunities they can leverage to support quality measurement, and 3) gave federal participants the opportunity to learn about state approaches to quality measurement and identify potential federal policy changes that can support state activities or better align federal strategies with state approaches.

Key themes that emerged from the discussion include:

- Federal and state partners have multiple options for aligning strategies, from using identical metrics to agreeing on a shared policy direction for value-based purchasing.
- In quality domains that have an excess of measures available, measures can be aligned across programs to reduce provider burdens.
- In areas of measure selection and development that suffer from a dearth of available measures, as well as in the ongoing development of the information technology infrastructure to support measurement, experimentation is necessary to identify promising paths forward.
- Measurement strategies should incorporate flexibility to accommodate changing needs and circumstances, as well as state-level variations in technical capacity and public health priorities.

Meeting participants generally agreed on a need for both levels of government to learn from each other and to focus policy on a goal of broadly supporting each other's initiatives by avoiding misalignment rather than the narrower goal of choosing identical quality measures.

THE NEED FOR QUALITY MEASUREMENT

Amid the burgeoning landscape of payment and delivery system reforms at both the federal and state level, quality measurement and reporting requirements have taken on new importance in recent years. Payers are increasingly seeking to reward *value*, understood as the health outcomes achieved per dollar spent, or the quality payers and consumers are getting for their spending.¹ Purchasing higher value services requires refining a precise definition of value—particular quality and cost goals—to enable the selection or development of appropriate quality measures. Operationally, it requires the existence of a data infrastructure that can support quality measurement and reporting. Finally, because the goal of rewarding value-based service provision is to foster it, value-based purchasing requires building the capacity to use quality data to drive improvement in health care delivery.

In the past, meaningful quality measurement has been stymied by:

- **Payment systems oriented toward rewarding volume.** As discussed in more detail in an earlier paper in this series, entrenched fee-for-service payment models that do not vary payment on the basis of value have dominated the health care system.² While federal and state payers are now beginning to realign payment policies to reward value, quality measurement has not historically been central to payment policy, diminishing its importance.
- **Underdeveloped quality reporting and measurement infrastructure.** As far back as 1998, a presidential advisory commission identified the need for a framework and capacity for quality measurement in the United States, including mechanisms for data reporting and collection.³ A 2004 Report to Congress from the Medicare Payment Advisory Commission found that levels of clinical information technology (IT) diffusion remained low, in part because “quality, a main reason for investing in IT, is not rewarded” and due to financial constraints.⁴ Over the last decade, states and the federal government have made strides to develop the infrastructure needed to measure quality in the health care system.
- **Lack of agreement on quality measures.** A recent study of performance measurement in commercial health plans found 546 distinct quality measures in use.⁵ Another recent analysis of state-organized measure sets found little alignment across a sample of 48 state and regional health care performance measure sets, with relatively few shared measures and widespread modification and tailoring of even those measures that are shared.⁶ Due to this wide variation, the federal government and consensus-building organizations like the National Quality Forum have recently worked to align measurement priorities as part of a National Quality Strategy.

Bolstered by recent policy impetuses at the federal and state level, a new emphasis on value-based purchasing has pushed quality measurement to the forefront of payment policy. New technological infrastructure is helping payers identify and reward high-value service delivery, while new mechanisms for building consensus on measures have emerged. The Affordable Care Act (ACA) of 2010 is launching new value-based purchasing initiatives within Medicare, promoting new quality measurement and reporting goals, and facilitating state-level value-based purchasing efforts through grant opportunities like the State Innovation Models initiative. At the same time, state-level reforms are increasingly leveraging quality measurement to hold providers and health plans accountable for the value of health services delivered.⁷ However, challenges remain in aligning federal and state efforts around identifying measurement priorities to reward value, integrating the supporting data infrastructure, and developing strategies for using data to drive system improvement.

PROJECT METHODOLOGY

In November 2013, NASHP convened and facilitated a discussion among high-level federal and state leaders. The meeting had multiple objectives: 1) state participants had the opportunity to learn about and discuss new opportunities and promising practices for measuring quality under value-based purchasing approaches with their peers, 2) states were able to learn about new federal opportunities they can leverage to support quality measurement, and 3) federal participants had the opportunity to learn about state approaches to quality measurement and identify potential federal policy changes that can support state activities or better align federal strategies with state approaches.

NASHP conducted an environmental scan and synthesized background information about the current quality measurement landscape and federal and state initiatives to incorporate robust quality measurement into value-based purchasing strategies. These findings were augmented with the meeting discussion to produce this report.

The meeting and this report are the third in a series exploring opportunities for aligning federal and state policies to achieve better quality, better health, and reduced costs. The first meeting explored potential for federal-state policy alignment to support emerging delivery models to link primary care providers not only to other medical service providers but also to resources in the community.⁸ The second report built on the first by considering payment reforms that support improved delivery of primary care, integration of care among primary care and other service providers, and transforming systems more broadly to achieve these goals.⁹

THE DRIVE TO MEASURE AND REWARD VALUE

More than a decade has passed since the Institute of Medicine (IOM) released two landmark studies on the quality of health care in the U.S.: the 1999 report *To Err is Human: Building a Safer Health System*, which focused on lapses in patient safety, and the 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, which detailed systemic quality gaps in health care delivery.^{10 11} These findings, coupled with IOM data showing that \$750 billion is lost annually to waste, inefficiencies, and other issues within the health care system have led to increasing urgency for payment and delivery system reforms that encourage quality improvement while maintaining or lowering costs.¹² Federal and state payers are taking advantage of new quality measurement infrastructure to support a variety of value-based purchasing initiatives.

DEVELOPING THE INFRASTRUCTURE TO SUPPORT QUALITY MEASUREMENT, REPORTING, AND IMPROVEMENT

Value-based purchasing inherently relies on accurate and meaningful quality measurement to guide reimbursement policies. Without the capacity to collect and interpret quality data, such payment policies are not possible. The quality measurement component of value-based purchasing has been facilitated in recent years by new technologies available to public payers, including new databases of administrative data, disease registries, and electronic health records (EHRs). Measures generally fall into three categories, each of which is often collected in a different way: structural, process, and outcome measures.¹³ Delivery system reforms like patient-centered medical homes and accountable care organizations are also relying on patient experience measures to identify value.

States are building databases of administrative data. New investments that are helping public payers to collect both the administrative (e.g., claims) data used to analyze process measures and the clinical data needed to measure outcomes are changing the face of quality measurement. All-payer claims databases (APCDs)—repositories of claims data from commercial insurers, Medicaid, prescription drug plans, dental insurers, self-insured employer plans, and, in some states, Medicare—have proliferated since Maine became the first state to require all payers to submit claims data in 2003.¹⁴ As of September 2013, eighteen states have or are implementing APCDs, while more than twenty other states have expressed strong interest in developing an APCD.¹⁵ APCDs provide a comprehensive source of information on use and cost of a range of health care services, offering a key facilitator for payment and delivery system reforms that rely at least in part on quality measures derived from administrative data.¹⁶

- **Structural measures** probe the resources, infrastructure (e.g., use of EHRs), and organizational context of care delivery.
- **Process measures** examine whether a recommended service was delivered, often using administrative (e.g., claims) data.
- **Outcome measures** gauge health status, ideally using clinical data.
- **Patient experience measures** collect patient perspectives on their care via surveys.

See: National Quality Forum. “The ABCs of Measurement.”
https://www.qualityforum.org/Masuring_Performance/ABCs/ABCs_of_Measurement.aspx

Federal and state governments are investing in health information technology. Recent major investments in health information technology (HIT), such as EHRs, public health registries, and health information exchanges have also expanded the possibilities for quality measurement using clinical data.

The Health Information Technology for Economic and Clinical Health (HITECH) Act launched a number of programs overseen by the Office of the National Coordinator for Health Information Technology (ONC). These programs helped to finance the development of statewide health information exchanges in every state, incentivized Medicare and Medicaid-participating providers to adopt EHRs, and seeded 17 Beacon Communities that demonstrated the potential of HIT to achieve better health and better care at a lower cost.¹⁷

Payers are leveraging technology to support improvements in care delivery. This shift toward electronic tools has created new opportunities for measurement and for offering feedback to health care providers. Providers receiving incentive payments for EHR adoption must demonstrate meaningful use of their EHRs, including reporting on clinical quality measures. In 2014, physicians must report to Centers for Medicare & Medicaid Services (CMS) on 9 of 64 clinical quality measures in order to receive federal incentive payments.¹⁸ Payers are increasingly utilizing physician performance feedback reporting systems to help clinicians understand their performance relative to peers and other benchmarks, as well as support performance improvement.¹⁹

THE SHIFT TOWARD VALUE-BASED PURCHASING

Recognizing that current payment policies are not fostering high-value service delivery (and in some cases are even inhibiting it), health care payers and purchasers are using this technology infrastructure to turn toward payment policies that facilitate quality improvement, improve population health, and slow cost growth. Public payers in particular are pursuing ways to pay for care models that integrate primary care, preventive services, acute care, behavioral health, and long-term services and supports to improve patient experiences and health outcomes.²⁰ The scope of these models is creating demand for a range of quality measures to ensure that the models are achieving their goals.

Public payers are launching new payment models.

A previous paper in this series explored federal and state initiatives along a spectrum of payment reform that builds outward from primary care-based strategies toward increasingly ambitious and expansive models.²¹ Public payers at both levels of government are experimenting with payment reforms centered on primary care, reforms radiating outward from primary care settings to facilitate links with other services, and finally strategies for building on these two approaches to create new, large-scale accountable care structures across settings and systems of care. These and other payment reform approaches have in common a growing reliance on quality measurement to ensure that new delivery models and the payment policies supporting them are rewarding higher value care delivery.²²

Pay-for-performance programs provide bonuses or other payment adjustments to providers based on absolute or relative performance on quality or efficiency indicators.

Patient-centered medical homes (PCMHs) provide team-based, coordinated care and often receive payment enhancements provided performance expectations are met.

Accountable care organizations (ACOs) distribute accountability for performance on cost and quality metrics across groups of providers, tying shared savings payments and other financial rewards to maintenance or improvement of care quality.

Payment models along this spectrum include pay-for-performance, patient-centered medical homes (PCMHs), accountable care organizations (ACOs), and other integrated care models.²³ The ACA contained a number of initiatives (described in more detail below) to encourage value-based purchasing in federal

health care programs, and states have increasingly been working to identify and incent higher value service delivery in state-level programs.

The federal government is encouraging state-level value-based purchasing. In addition to supporting these models directly through federal health purchasing programs, CMS recently encouraged states to implement payment reforms that reward and improve value; it issued guidance in 2012 on these integrated care models to help states design initiatives and navigate the Medicaid State Plan Amendment process.²⁴ Quality measurement components of the options and considerations suggested for states included:

- using attribution methods that give “reasonable assurance a provider’s intervention can be connected to improved health care outcomes”
- developing a tiered payment methodology that pays one rate for providers who report process measures, and a higher rate for providers who also report outcomes based quality measures
- calculating a payment based on shared savings and rewarding providers for the quality improvements or outcomes

This guidance reflects the growing emphasis on quality measurement that is accompanying federal and state efforts to promote value-based purchasing.

ALIGNING MEASUREMENT PRIORITIES TO SUPPORT VALUE-BASED PURCHASING

At the same time that payment and delivery system reforms are increasingly relying on quality measurement, a national quality agenda is being developed.²⁵ The ACA called for the creation of a National Quality Strategy to improve care delivery, patient outcomes, and population health. Among the ten principles for this strategy identified by the Department of Health and Human Services (HHS) is a commitment that “Consistent national standards will be promoted, while maintaining support for local, community, and state-level activities that are responsive to local circumstances.”²⁶

Public and private sector partners are working to align priorities. HHS has tasked the National Quality Forum, an organization with a history of building consensus on measurement priorities and standards among diverse health care stakeholders, with convening a public-private Measure Applications Partnership (MAP) to help align quality measure selection across public and private-sector reporting. The MAP released a three-year strategic plan in late 2012 describing its goals and approach.²⁷ Similarly, ONC has worked with private sector partners to launch a Health eDecisions Standards and Interoperability Initiative to standardize clinical decision support tools used to improve quality.²⁸

The federal government is aligning quality measurement across agencies. In its “2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care,” HHS detailed several of the department’s efforts to align quality reporting requirements across federal health reform programs.²⁹ A Measurement Policy Council has worked to harmonize quality measurement across HHS and meet the goals of the National Quality Strategy since 2012.

CMS is working to align reporting requirements for three mandatory quality programs: the Physician Quality Reporting System, the physician value-based modifier for Medicare, and the EHR incentive program. By 2014, providers will be able to satisfy all three programs simultaneously by reporting on a single set of measures.³⁰ Other agencies such as the Health Resources and Services Administration are working to reduce the reporting burden on community health centers and other organizations by aligning with CMS measurement requirements.³¹

States are building consensus and aligning at the state level. Eight states participated in an HIT Trailblazers initiative sponsored by ONC. This project supported states' efforts to align performance measurement across state-level delivery system transformation initiatives and move toward HIT-enabled measurement, including aligning quality measurement priorities across stakeholders.³²

Figure 1. Select Federal Measurement Sets

Measure Set	Reporting	Purpose
Physician Quality Reporting System ³³	Currently voluntary; payment adjustments for non-reporting begin in 2015	Assess quality of care being provided to Medicare beneficiaries; provide feedback to providers on comparative performance
Meaningful Use ³⁴	Required for EHR incentives	Ensure EHRs have the capacity to measure and report on clinical quality measures
CHIPRA Initial Core Set ³⁵	Voluntary	Monitor health outcomes for children in Medicaid and CHIP
Adult Medicaid Initial Core Set ³⁶	Voluntary	Monitor health outcomes for adults in Medicaid
ACO Quality Measures ³⁷	Required for ACO participants	Monitor performance to ensure savings do not harm quality

Governments are identifying measure sets for use in public programs and processes for continuous improvement of public measure sets. Federal and state initiatives that rely on quality measurement have identified existing relevant measures to gauge performance. The federal government has also moved to identify core measure sets and processes for updating them to guide program improvement in the future. The Children's Health Insurance Program Reauthorization Act (CHIPRA) called for the creation of an initial core set of children's health care quality measures, as well as the establishment of a Pediatric Quality Measures Program to enhance and improve the initial core set, evaluating other potential measures for inclusion in the set.^{38 39} The initial list of measures, originally posted for public comment in December 2009, drew from a number of existing measure sets.⁴⁰

The ACA similarly required the creation of an initial core set of adult health care quality measures for Medicaid-eligible adults, and the establishment of a Medicaid Quality Measurement Program charged with "development, testing, and validation of emerging and innovative evidence-based measures" for use in the Medicaid adult core set.^{41 42} The initial adult core set was released in January 2012.⁴³ The federal government and states have also identified measure sets for reporting in payment reform programs, such as accountable care initiatives.

It is against this backdrop of new measure set identification and development processes that the federal government and states are increasingly paying based on the quality of care provided.

QUALITY MEASUREMENT TO SUPPORT VALUE-BASED PURCHASING AT THE FEDERAL AND STATE LEVEL

Reforms at the federal and state level have paved the way for value-based purchasing initiatives, increasing the importance of quality measurement to health care purchasing. Public payers are working to ensure that while quality measurement approaches within value-based purchasing initiatives meet the goals of the particular program, they also conform with a broader quality agenda, the emerging National Quality Strategy, to the maximum extent possible. Each payment reform initiative incorporates quality metrics that reflect its priorities and the understanding of value it is seeking to promulgate and reward. Each also reflects the reporting capabilities of participating providers or entities.

FEDERAL QUALITY MEASUREMENT STRATEGIES

The federal government is moving to tie payment to quality, particularly in the Medicare program. It is aligning across federal agencies and leveraging quality measurement to improve quality at the health plan and provider level, as well as to support accountable care delivery.

CMS is measuring at the plan level to improve quality. The federal government is moving to reward value not only through direct reimbursement of health care providers, but also by aligning capitation payments to the private insurance plans participating in the Medicare Advantage program with performance.⁴⁴ In 2008, CMS began assigning star ratings to Medicare Advantage plans based on plan performance on a number of measures.⁴⁵ Plan performance is rated on a scale of 1 (poor) to 5 (excellent). Star ratings for plans in 2014 are based on measures from:⁴⁶

- The Health Effectiveness Data and Information Set (HEDIS), a widely used set of mostly process measures that gauge performance of health plans;⁴⁷
- The Medicare Health Outcomes Survey (HOS), a set of patient-reported outcomes measures;⁴⁸
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS), standardized patient experience surveys;⁴⁹ and,
- Administrative data.

Under the ACA, performance on the star rating system became the basis for bonus payments to Medicare Advantage plans beginning in 2012. The law allowed for bonus payments to plans receiving star ratings of four or higher. CMS has gone further, establishing a Medicare Advantage Quality Bonus Payment Demonstration that increased the size of the bonuses and extended eligibility for bonus payments to Medicare Advantage plans receiving ratings of 3 and 3.5.⁵⁰

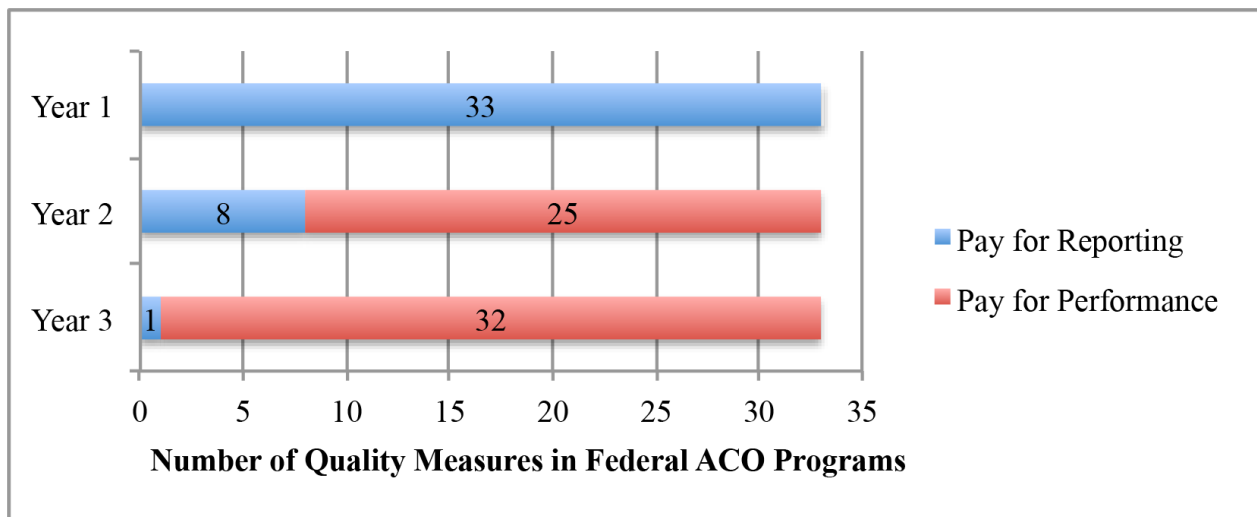
Measurement is helping Medicare to purchase value from providers and health systems. The ACA also authorized a Hospital Value-Based Purchasing (VBP) Program that provides incentive payments to hospitals based on performance on quality measures. The program is linking payments to how well hospitals perform on select measures, or how much the hospital improves on each measure compared to performance during a baseline period.⁵¹ The VBP Program launched with clinical process of care and patient experience of care measurements for fiscal year 2013 and will phase in additional measures in the coming years.⁵² The program will add outcome measures beginning in FY 2014 and efficiency metrics in FY 2015. Similarly, under the Readmissions Reduction Program authorized by the ACA, hospital performance on NQF-endorsed hospital readmissions measures (initially for acute myocardial infarction, heart failure, and pneumonia) will be the basis for potential reductions in Medicare payment rates to hospitals beginning in FY 2013.⁵³

The ACA also requires that CMS begin linking payments to physicians under the Medicare Physician Fee Schedule to value by 2015. This value-based payment modifier will be based on quality and cost data obtained through the Physician Quality Reporting System and by 2017 will affect all physicians participating in the fee-for-service Medicare program.⁵⁴ This initiative builds on and is required to be aligned with the Physician Feedback Program created by the Medicare Improvement for Patients and Providers Act of 2008.

Under the feedback program, physicians receive Physician Quality and Resource Use Reports (QRURs) that provide comparative information on utilization of various clinical services and Medicare spending for each physician's Medicare patients.⁵⁵ The QRURs will be used in the future to display quality and cost data that will comprise the value-based payment modifier, helping physicians to compare their performance to peers and learn how their payments will be impacted by the modifier.⁵⁶

Measurement is supporting accountable care delivery. Under the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Program, CMS is recognizing groups of providers that band together to form ACOs and allowing them to share in savings if quality standards are met. ACOs in both programs are subject to the same quality performance measurement requirements.⁵⁷ In the first year of operation, successfully reporting on all 33 required quality measures satisfies the program's quality standards and qualifies ACOs for the maximum shared savings rate. However, in subsequent years the program shifts from paying for reporting on quality measures to paying for performance on select measures.⁵⁸

Figure 2. Number of Quality Measures in Federal ACO Programs



The federal accountable care programs are relying on quality measures that gauge:

- Patient and caregiver experience,
- Care coordination and patient safety,
- Preventive health, and
- Diabetes, hypertension, ischemic vascular disease, heart failure and coronary artery disease measures for at-risk populations.

Measurement is supporting a whole-person perspective and holding programs accountable. The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a National Outcome Measures reporting system to gauge outcomes related to mental health services, and substance

abuse treatment and prevention.⁵⁹ These measures focus on ten different domains that provide a whole-person view of individuals, including outcomes related to employment and education, stability in housing, and social connectedness. The National Outcome Measures help to establish performance targets for federally-funded programs offering behavioral health prevention and treatment services.

STATE QUALITY MEASUREMENT STRATEGIES

States have in place a range of quality measurement strategies to support value-based purchasing, as well as attempts at achieving alignment within and beyond the state. Below are illustrative highlights from select states.

States are measuring quality at the plan level in state-based exchanges. While value-based purchasing often refers to direct engagement with health care providers, states are also planning to drive quality improvement by measuring and displaying plan-level quality ratings in the health insurance exchanges created by the ACA. This will allow consumers to gauge the value of plan offerings. All exchanges—state-based and federally-facilitated—will display quality ratings by 2016, but some states have indicated that they will display quality data beginning in 2014.⁶⁰

The state of **New York** will rely on an existing quality reporting system that has been in place for commercial and public health plans for nearly two decades, known as the Quality Assurance Reporting Requirements.⁶¹ These measures will be a mix of HEDIS data and consumer experience of care data from the CAHPS. Other states, like **Rhode Island**, are developing measures for use in gauging health plan performance in their exchanges.⁶²

States are relying on national measure sets to make payments linked to value. Some states have developed measure sets for use by providers participating in delivery system reforms or to measure quality more generally. These measure sets tend to draw from existing nationally recognized quality measures, although a recent analysis found that programs often modify at least one standardized measure to meet the needs of the program.⁶³

Michigan has a multi-payer PCMH program, the Michigan Primary Care Transformation Project, that offers providers performance incentives in the form of an additional per-member per-month payment.⁶⁴ Many of the quality measures used to gauge PCMH performance are drawn from HEDIS.⁶⁵ **Rhode Island's** multi-payer PCMH initiative, the Chronic Care Sustainability Initiative, contains payment incentives linked to performance targets. Per-member per-month payments to the PCMHs are tiered, with higher payments offered to higher-performing PCMHs.⁶⁶ Among other utilization and quality measures, the initiative's performance targets draw from the CAHPS—PCMHs that achieve greater than 80 percent of patients being “satisfied” or “very satisfied” on the patient experience surveys have met one of the initiative's quality targets.⁶⁷

States are building data infrastructure to support payment reform and to drive improvement.

States are relying on new data and reporting infrastructure to gauge performance and support feedback to physicians. **Vermont** has moved to improve primary care in the state through its Blueprint for Health, an attempt to orient the state's delivery system around medical homes and community health teams. The state is supporting these efforts with a robust data infrastructure that is evaluating and working to improve health care quality. Practices can share data with the state's central clinical registry, known as Covisint-DocSite, using the Vermont Health Information Exchange or, for practices without an electronic health record, using a web portal.⁶⁸

In **Arkansas**, the state Department of Human Services (which houses Medicaid) has partnered with private payers on a Health Care Payment Improvement Initiative that is paying providers based on performance for select episodes of care.⁶⁹ As part of this initiative, providers are being offered performance reports through a web-based provider portal. These reports detail cost, quality and utilization indicators for episodes of care for which the provider bears responsibility.⁷⁰ The reports provide information on performance relative to other providers, as well as notifications of whether the provider has achieved gain sharing, loss sharing, or no change in payment for each episode of care.

Colorado launched an Accountable Care Collaborative initiative within Medicaid in 2011. Under this initiative, Regional Care Coordination Organizations (RCCOs) provide medical management and care coordination support to primary care practices.⁷¹ The state's strategy relies on a Statewide Data Analytics Contractor to maintain a comprehensive data repository, provide data analytics to measure performance, and offer stakeholders access to information via a web portal.⁷² The initiative began by tracking three key performance indicators that were used to issue incentive payments to RCCOs: emergency room visits, 30-day hospital readmissions, and high-cost imaging.⁷³ A fourth performance indicator measuring well-child visits was added in 2013.

States are using quality measures to hold large providers and systems accountable. States are also moving to leverage quality measurement in value-based purchasing initiatives to encourage accountability by hospitals and entities that manage care across a continuum of services.

In **Maryland**, the state's Health Services Cost Review Commission implemented a Quality Based Reimbursement initiative for hospitals in 2009.⁷⁴ Building on the state's unique all-payer rate-setting system that creates consistent financial incentives for hospitals, the initiative funds higher rates for better-performing hospitals by decreasing rates for lower-performing hospitals.⁷⁵ Hospitals are rewarded or penalized based on the higher of two metrics: absolute performance on quality measures as compared to state benchmarks, and improvement relative to the hospital's performance during an earlier baseline period. The initiative initially relied on process measures focusing on heart attack, heart failure, pneumonia, and surgical infection prevention domains.⁷⁶

Oregon has launched Care Coordination Organizations (CCOs) within its Medicaid program to provide integrated and coordinated care across a range of services under a global budget. The state offers incentive payments to CCOs based on performance on cost and quality metrics. In selecting appropriate measures, the state examined a number of existing measure sets, including the Adult Medicaid Quality Measures and the CHIPRA core set.⁷⁷

Other states are relying on statewide reporting systems to support value-based purchasing initiatives.

Minnesota's Department of Health was required by statute to establish a standardized set of health care quality measures. In response, the department created the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) in late 2009.⁷⁸ The state's Health Care Delivery Systems Demonstration, a shared savings accountable care program within Medicaid, is tying eligibility for savings payments to performance on select measures reported as part of the SQRMS. The 10 measures used in the demonstration were chosen to ensure quality in the demonstration is high across health care process, outcomes, and patient experience domains, without creating new reporting requirements.⁷⁹

In 2012, **Massachusetts** enacted a series of health reforms aimed at containing health care costs. This law required the development of a Standard Quality Measure Set—consisting of measures

chosen from existing national measure sets—for use in state initiatives to improve quality and reward value.⁸⁰ In developing its recommended measure set, the committee charged with this task explicitly attempted to align the state’s quality strategy with federal health initiatives, including the priorities identified in the National Quality Strategy, while still meeting the needs of Massachusetts’s reforms.⁸¹ These measures will be used to evaluate delivery models in Massachusetts supported by new payment policies, including PCMHs and ACOs.

OPPORTUNITIES FOR POLICY IMPROVEMENT

The variations in value-based purchasing initiatives and in the accompanying quality measurement strategies at the federal and state levels have left room for policy improvement. Participants at the November meeting convened by NASHP saw a need for both levels of government to learn from each other and to focus policy on a goal of broadly supporting each other's initiatives by avoiding misalignment, rather than the narrower goal of choosing identical quality measures.

MULTIPLE APPROACHES TO POLICY ALIGNMENT AROUND QUALITY MEASUREMENT MAY BE APPROPRIATE.

Misalignment between federal and state measurement strategies can undermine value-based purchasing initiatives if they send mixed clinical messages to the providers driving quality improvement. Variations in measure selection between programs can also undermine the goal of measuring and paying on the basis of comparative performance if measures are not comparable across programs. Yet the federal government and states often have valid reasons for choosing different measures or modifying national measures to meet the needs of a particular initiative. Differences in the populations targeted and served by different payers, varying programmatic goals, and different stakeholders of the entities providing direction to value-based purchasing initiatives can all result in misalignment of measures. The November 2013 meeting surfaced two distinct approaches to federal/state alignment.

Participants introduced the concept of *horizontal alignment*, in which quality measures are harmonized across concurrent initiatives to promote uniformity; the federal government's effort to move toward a single measure set for the Physician Quality Reporting System, the physician value-based modifier for Medicare, and the EHR incentive program is an example of horizontal alignment. Horizontal alignment of specific metrics across programs may serve the goal of diminishing the reporting burden of value-based purchasing initiatives on providers, a particularly important consideration for voluntary initiatives that rely heavily on provider buy-in for success. However, this approach may miss an opportunity to achieve a more expansive alignment of measurement approaches and concepts across settings to achieve a more systematic approach to rewarding value.

Horizontal alignment was contrasted with *vertical alignment*, in which explicit duplication of metrics across programs is rendered unnecessary by using a broader approach to alignment, one in which payers and others commit to a shared policy direction even if they differ in the details of their approaches. One participant suggested a public health example of vertical alignment: a program that looks at population-level smoking cessation measures would be vertically aligned with a program that focuses on community-based measures of tobacco taxes and smoking policies, as both would be part of a broader strategy to discourage tobacco use. Similarly, an outcome measure of preventable hospital readmissions would be vertically aligned with a structural measure of whether hospitals have in place community transitions programs or other linkages with community-based and primary care providers. While the measures are not the same, they are directionally aligned, with both getting at the same policy priority of examining whether providers are working to avoid preventable readmissions.

Participants suggested that a vertical alignment approach, in which a policy or public health goal is pursued across initiatives and departments even if measures are not entirely shared, may better support the idea of "system-ness." For instance, under its State Innovation Models initiative, **Minnesota** intends to pursue vertical alignment, supporting directional alignment and consistency in signals to providers across payers in the state.

In line with their concept of vertical alignment, participants also discussed opportunities for a more modest alignment approach across payers based on harmonizing the structure of measurement strategies. Federal and state initiatives may align on details of value-based purchasing models like attribution models, applying consistent methods to determining providers' accountability for populations as a first step. These initiatives could agree on consistent periods of performance for measuring quality to reduce the variation in demands on providers. While this approach would see federal and state programs align not on specific measures but rather on how they go about measuring, this approach would ease the burden on providers and pave the way for more explicit alignment on metrics in the future.

FEDERAL AND STATE OFFICIALS CAN ALIGN ON METRICS IN MEASURE-RICH QUALITY DOMAINS.

Despite recognizing that there are key variations in their understanding of alignment, officials at the meeting agreed that there is a serious need for greater alignment of quality measurement strategies across some value-based purchasing initiatives. Participants felt that if providers are going to be paid for some measured output, payers must give them a system that is as easy to understand as the current system of paying for health care “widgets.” Streamlining reporting requirements and offering a simple, consistent definition of value to providers is an important step in this direction. Building on the idea of horizontal alignment, participants noted that some quality domains have an excess of measures available and could benefit from some consolidation across programs. Officials stressed the mantra “don’t reinvent the wheel” in developing measurement strategies and selecting measures.

Quality domains with an overabundance of available measures pose logistical challenges for policymakers. States do not have the capacity to sift through and analyze hundreds of potential quality metrics: in discussing a state agency’s limitations when identifying the best quality measures for a given value-based purchasing strategy, one state official declared “what we don’t have is the ability to objectively evaluate 1,500 metrics.” Another state official noted the challenges of retiring measures due to pressure from affected stakeholders, leading to ever-growing measure sets.

Some participants suggested a need for alignment not only across levels of government but between reform strategies. While value-based purchasing focuses on implementing reimbursement methodologies that reward providers for offering higher value services, some states are contemplating value-based insurance design strategies designed to bring the consumer into the value determination process. These approaches emphasize using insurance benefit designs—cost-sharing provisions in health plans—and public reporting on quality indicators to encourage and help consumers choose higher-value services. By fostering and rewarding a consistent understanding of value from both the payer side and consumer side, policymakers could align bottom-up and top-down approaches to rewarding value. **Maryland** is exploring ways to encourage value-based insurance in its insurance exchange and Medicaid program as part of the state’s broader strategy to encourage higher-value service delivery.

THERE ARE AREAS IN WHICH FEDERAL/STATE ALIGNMENT IS NOT YET POSSIBLE OR PREFERABLE.

Despite the imperative for and benefits of greater alignment discussed above, meeting participants agreed that in certain circumstances a degree of misalignment—state or program-level variation—is acceptable and preferable.

In some areas of measure selection and development, as well as in the ongoing development of the information technology infrastructure to support measurement, experimentation is necessary to identify promising paths forward. For instance, participants suggested that there is a need to explore the use of new hybrid measures that rely on both administrative and clinical data, or that incorporate human services

data sets. Measures are often lacking for areas like behavioral health, quality of life, care coordination, and the social determinants of health. In these areas, where not enough is known about what does and does not work well, learning is more important than alignment. Payers must be allowed and encouraged to test different strategies and approaches to quality measurement.

State officials noted that alignment of state approaches with federal measurement strategies, as well as with measurement strategies pursued by commercial payers, is necessary for ensuring that providers are receiving consistent messages on value. However, state officials saw little reason to consciously align with other states. Participants from both levels of government conceded that there may be good reasons to modify measures locally to account for varying circumstances or programmatic goals. States must also consider payment signals being sent to providers by prominent commercial payers when devising their own strategies. States like **Rhode Island** that have large national payers in their insurance markets must contend with commercial payers who may be unwilling to modify payment strategies for small markets.

Participants felt that states are often not yet ready to align with the federal government or with each other on the technical aspects of measurement because many states are not sufficiently far along in developing an infrastructure and using it to identify best practices for collecting and using quality data. Even in states like **Vermont** that have been building data infrastructure like a health information exchange and centralized registry for some time, challenges remain in getting necessary data to and from providers. At the same time, federal officials acknowledged that the federal government is also still learning as the meaningful use criteria for electronic health records continue to evolve.

FLEXIBILITY IS NEEDED AT THE STATE LEVEL WHEN STATES ARE DESIGNING MEASUREMENT STRATEGIES AND INFRASTRUCTURE.

Throughout the day, state participants at the meeting reiterated a theme that flexibility must be incorporated into any quality measurement strategy. Participants stressed the importance of building a quality measurement and reporting infrastructure that is adaptable to the ever-evolving needs of purchasers. One emphasized that federal and state officials alike “need to try to think ahead of what the next wave of measures is going to be.” Another put it simply: “we need to skate where the puck is going to be.”

The imperative to be adaptable to changing needs and circumstances is not the only reason participants desired flexibility, however. Variations between states and the federal government and between the states themselves are also significant. There was agreement at the meeting that national standards can be appropriate and useful when measuring quality in health care processes and outcomes. In particular, the opportunity for national benchmarking of performance offers opportunities for improvement. One state official related that after comparing his institution’s performance to national benchmarks a hospital executive shared a revealing insight: “I thought we were doing great at [preventing] re-hospitalizations but we’re not—I was only looking within my state.”

However, participants pointed out that public health priorities are inherently local, and state environments and technical infrastructures vary widely. Some states recognize that they will never have a central repository of clinical information due to local political culture, while other states have greater latitude to collect and centrally store such information. Some states have broader authority to require participation in multi-payer value-based purchasing initiatives, while others must rely more heavily on voluntary participation. Some states have been working to develop health information technology infrastructure for many years, while others are relative newcomers. Federal measurement strategies and infrastructure investments must remain flexible to take into account these variations.

PULLING IT TOGETHER: COMPILING NEXT STEPS FOR THE FEDERAL GOVERNMENT AND STATES

The considerations described above offer possible steps for federal and state partners as they seek to align quality measurement strategies to support a value-based purchasing agenda. Experts at the meeting made the following suggestions:

- CMS can work to routinely make state-level Medicare claims data available to states for use in designing and administering quality measurement strategies to support value-based purchasing.
- The federal government and states can explore opportunities for aligning on quality measurement approaches, developing consistency on elements such as attribution models when explicit measure alignment is not feasible.
- CMS can work to align core measures for adults and children with other measure sets produced by CMS (like the PQRS) and measures produced by agencies that interact with Medicaid-eligible populations, like HRSA and SAMHSA.
- The federal government could provide an informational “guide for states” on developing quality measurement strategies and infrastructure to help states get started in designing new initiatives.
- Federal and state officials can explore ways to better use existing infrastructure to support a unified quality measurement agenda. Officials at both levels of government can collaborate in considering ways to use community needs assessment processes and contracts with Medicare Quality Improvement Organizations in each state to support value-based purchasing initiatives.
- Federal partners could sketch out a clear direction and vision for the future evolution of value-based purchasing and quality measurement at the federal level. State officials stressed that they need a “clear line of sight on where federal policy is going” in planning and designing their own approaches if alignment is to be possible in the future.
- The federal government and states can consider collaborating on a consistent menu of metrics for providers. While the subset of metrics chosen for use by providers or particular initiatives may vary, identifying a uniform menu can support greater alignment.

CONCLUSION

Accurate and reliable quality measurement is increasingly important to federal and state payment strategies. A new generation of technical infrastructure is enabling payers at both levels of government to define and identify high-value service delivery. Recent reforms, including the ACA, are pushing payers to become more prudent purchasers of care, spurring them to implement payment strategies that reward value in the health care system. At the same time, a National Quality Strategy and mechanisms to reach consensus on quality metrics are emerging to more precisely define what quality—and thus value—mean in health care.

Achieving a greater degree of alignment between federal and state initiatives is important because these strategies may affect the same providers. Even when they do not impact the same providers, using competing definitions of and rewards for quality may lead to health disparities between populations. Yet alignment can take multiple forms and is not always desirable. In areas of quality measurement with a preponderance of competing validated quality metrics, adoption of a single measure by initiatives that share the same goals may be a good idea. In emerging areas where experimentation is still needed, flexibility is necessary to help states and the federal government find the best path. Flexibility is also required to accommodate variations in state-level priorities and capacities. As a result, payers at both levels of government may need to settle for directional alignment where possible, echoing similar themes and messages on quality to providers even if selecting identical quality metrics is not feasible.

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