CQMC Implementation Guide

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Contents

About the Core Quality Measures Collaborative

The Core Quality Measures Collaborative (CQMC) is a public-private partnership working to address the proliferation of measures by facilitating cross-payer measure alignment. The CQMC was convened in 2015 by America's Health Insurance Plans (AHIP). CQMC membership includes the Centers for Medicare & Medicaid Services (CMS), health insurance providers, medical associations, consumer groups, purchasers (including employer group representatives), and other quality collaboratives working together to recommend core sets of measures by clinical area to assess the quality of healthcare in the United States (U.S.). The CQMC is a voluntary effort in which members choose to participate and subsequently promote the adoption of the core measures.

Executive Summary

The U.S. healthcare system is transitioning from one that pays for the volume of services to one that pays for value. Value-based payment (VBP) programs rely on quality, patient experience, efficiency, and other performance metrics to assess the success of alternative payment models (APMs) and their participants at delivering value.

Increased reliance on performance measurement as part of these models has led to a corresponding expansion in the number of measures. This growth increases burden on providers implementing the measures, causes confusion among consumers and purchasers who see conflicting measure results, and exacerbates complex operational difficulties among stakeholders. The CQMC is a public-private partnership working to address the proliferation of measures by facilitating cross-payer measure alignment through the creation and adoption of core measure sets. These core sets, as part of payment programs, can help an organization prioritize and streamline measurement and improvement efforts.

Moving from fee-for-service to more advanced payment models is challenging. It is not uncommon for initiatives to fail, though when they succeed, they have been shown to successfully improve quality and outcomes while reducing costs. This Implementation Guide identifies key elements of success for using the CQMC core measure sets in VBP programs and APMs and synthesizes strategies and resources to help an organization succeed. The four elements of success for VBP implementation are the following:

1. **Leadership and Planning**
   Senior leadership support from both the payer administering the APM and the provider accepting the payment model is crucial to the success of VBP efforts. Implementation of VBP programs and core sets within these programs flows from, and feeds into, strategic planning and relationship building.
2. **Stakeholder Engagement and Partnership**
   Advancing performance measurement and payment models will require strong relationships, cooperation, and trust. Innovation in payment, performance measurement, and care models requires collaboration. Healthcare organizations, including both payers and providers, will need to work together in new ways.
3. **Voluntary Measure Alignment**
   Voluntary measure alignment among both public and private payers provides clarity to stakeholders and allows work to focus on adding value through improvement and reducing resources to manage multiple, potentially conflicting, measures and specifications.
4. **Data and Quality Improvement Support**
   VBP can only result in system transformation when all stakeholders have the necessary data, information, and resources to improve and transform. Payer and provider organizations participating in APMs will need to source and share data in new ways to support this transformation.

The CQMC considers these elements of success as integral components of VBP or APM implementation. The CQMC core measure sets are a place to start when implementing these programs. These sets are composed of measures already vetted and maintained by experts in the applicable clinical field. In addition, the CQMC is advancing high-priority areas, such as digital measurement and health equity. Combined, these efforts in the quality measurement field will advance the health of all Americans.

Background

Stakeholders increasingly rely on quality and performance measures as part of the ever-growing development and use of VBP and APMs. This has led to a proliferation of measures to implement, collect, improve upon, and maintain. There has been a corresponding increase in burden on providers working to improve performance across many measures, confusion among consumers and purchasers seeing varied or conflicting measure results, and operational difficulties among public and private payers and other stakeholders.

The CQMC was founded in 2015 to provide a foundation for voluntary alignment of public and private payers on measures to assess healthcare quality; provide useful information for improvement, decision making, and payment; and reduce measurement burden in the U.S. The CQMC is a membership-driven and funded effort with representation from a variety of healthcare stakeholders, including public payers such as CMS, medical associations, health insurance providers, consumer groups, purchasers and employers, and regional quality collaboratives. The CQMC convenes multistakeholder Workgroups to develop and implement core measure sets in specialty areas and to develop guidance in high-priority areas of measurement innovation (i.e., Health Equity, Measure Model Alignment, Digital Measurement, and Cross-Cutting Measures).

The CQMC's core sets are groups of scientifically sound measures that promote patient-centered assessments of quality; these core sets are created for voluntary use in VBP programs and APMs. CQMC members select core set measures based on multistakeholder consensus. They prioritize measures that meet a high bar for selection, such as outcome and patient-reported outcome performance measures (PRO-PMs); digital quality measures (dQMs); and measures addressing cross-cutting topics, including health equity and disparities. CQMC members update these core sets annually to reflect the changing measurement landscape, such as changes in evidence-based clinical practice guidelines, data source availability or preference, and risk adjustment.

To date, the CQMC has developed 10 core sets addressing the topic areas below. The core sets focus primarily on ambulatory care (outpatient setting) measures at the clinician or clinician-group level of analysis.

1. Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMH), and Primary Care
2. Cardiology
3. Gastroenterology
4. HIV and Hepatitis C
5. Medical Oncology
6. Obstetrics and Gynecology
7. Orthopedics
8. Pediatrics
9. Neurology
10. Behavioral Health

Meeting the needs of varying stakeholders for multiple applications of measurement (e.g., public reporting, provider feedback reports, or VBP) is a challenging task. The CQMC core sets are not intended to cover every possible scenario for stakeholders; while the sets can be used in their entirety to holistically assess quality, they can also serve as a starting point for alignment, in which organizations choose measures from within the core sets when possible.

While the CQMC core sets are a valuable resource for measure alignment, a 2019 survey of 30 health plans found significant variation in core set measure adoption and highlighted the benefit to consumers, providers, and others of removing obstacles to the implementation of and increasing the use of the core measures. Claims-based measures had the highest rates of use, with plans citing significant barriers to using measures that rely on clinical data due to a lack of infrastructure for reporting and collecting these data. Other barriers to core measure implementation included small sample sizes and the need for increased provider education about measures.

Based on these challenges, the CQMC established an Implementation Workgroup in late 2019. The charge of the Implementation Workgroup is to discuss barriers to the implementation of the CQMC core sets, as well as identify solutions and strategies to address these issues to make possible greater voluntary core set adoption. The Workgroup's discussion informed the initial creation of this Implementation Guide in 2020 and the subsequent updates made in 2021 and 2022. The current Guide summarizes strategies to implement the core sets successfully voluntarily in VBP programs, resulting in greater measure alignment, decreased burden for providers and other stakeholders a foundation for improved healthcare quality and outcomes for consumers.

Using This Guide

The primary audience for this Implementation Guide is health plans considering implementing or refining their VBP program. While intended primarily for plans, a broad set of stakeholders, including providers, purchasers, regional collaboratives, and policy and regulatory bodies, may find the content valuable to help enable increased measure alignment and broaden education about the value of healthcare performance measurement.

Stakeholders can consider the implementation strategies as they design, refine, strengthen, and expand their organization's VBP initiatives and address barriers and challenges to using the CQMC core sets in VBP programs. The Implementation Guide is not a list of "must-dos"; rather, it offers a range of options that stakeholders can voluntarily chose from depending on their own context, resources, and needs. The implementation strategies include content for stakeholders who are early in their efforts to incorporate measurement into VBP approaches, as well as plans seeking to strengthen and sustain existing initiatives.

The Implementation Guide is organized by key elements of success for VBP programs and core measure set adoption. We define success as full implementation of a program that increases the value of care for patients through improved health outcomes and resource stewardship. Details of contractual or payment arrangements are matters for individual plans and are outside the scope of this guide. Each element of success includes a brief description, key takeaways, implementation strategies, potential barriers and suggested solutions, and curated tools and resources that provide more in-depth information and guidance on relevant topics. Appendix A includes links to these tools and resources that

may cross multiple areas. The Guide also includes information, strategies, and resources on drivers of change and efforts to advance measurement.

This guide is not intended to be a definitive list but rather a compilation of shared learnings and best practices. The strategies in this guide are potential, voluntary solutions to successfully implement a VBP program. The extent, manner, and scope of use of these strategies are decisions for each individual plan to make independently.

Elements of Success for Value-Based Payment Implementation

The CQMC identified four elements for successful VBP implementation:

1. Leadership and Planning
2. Stakeholder Engagement and Partnership
3. Voluntary Measure Alignment
4. Data and Quality Improvement Support

While these elements are explored in separate sections for ease of navigation, the elements are interrelated, and all are necessary for successful VBP implementation.

Element of Success 1: Leadership and Planning

Strong and committed leadership across payers and providers is foundational for success in payment transformation. Successful and lasting change requires clear and consistent support and reinforcement at all organizational levels. In addition, it is important that leadership commits to fostering a culture that emphasizes quality, innovation, and change. Leadership is essential to building the relationships and trust necessary for lasting partnerships.

Implementation Considerations

- ❑ **Assess organizational readiness and institutional commitment**
- Review your plan and participating providers to determine what VBP arrangements or quality measurement initiatives are already in place and identify any differences
- Assess the technological capabilities of the plan and participating providers to understand what data and measures are feasible to use as part of a new measurement initiative
- Create an inventory of available data and measures already in use
    - Review sources such as data available through internal and external stakeholders; regional, state, and national data; or data sets available for purchase
    - See Element of Success 4: Data and Quality Improvement Support for more strategies and resources on data and data sharing
- Determine leadership's understanding and readiness to change
- Cultivate, promote, and maintain a culture that emphasizes innovation and change and allows for failure (i.e., learning opportunities)
- Guarantee institutional initiatives with three-year contingency plans to ensure consistency during unforeseen transition

Note: You may need to rebalance measures as you move from fee-for-service–based payment models to population-based payment models. Payment for the volume of services has led to concerns about potential overtreatment. Shifting to payment models, such as global budgets, may shift concern to undertreatment.

❑ **Determine priority care areas and stakeholders**

- Decide on the overall goals of your program, focusing on the populations and conditions you want to address, the barriers you want to remove, and the behaviors you want to encourage
- Consider starting by focusing your program on a limited set of prioritized measures with a broad impact on population health (e.g., cancer screenings, immunizations, blood pressure control, and control of Hba1C for individuals with diabetes)
    - Consider using relevant CQMC core sets, whether for full populations (e.g., ACO/PCMH/primary care core set) and/or condition-specific core sets (e.g., cardiology, medical oncology)
- Consider whether it would be beneficial to use voluntarily aligning measurement and measurement strategies (e.g., through the use of the CQMC core sets) to increase signal and reduce burden, including update cycles
- Gain leadership buy-in and multidisciplinary support from clinical, technical, and measurement staff, as well as well-respected leaders across the organization
- Identify a clinical champion and non-clinical leader who can provide guidance and engage others, including clinicians, in the work. Provide administrative support to encourage efficiency.
- Identify potential partners and stakeholders who will set the project up for success, based on whether the solution will be purchased, built internally, or built through an external partnership
    - Leverage senior leaders as active and engaged project sponsors
    - Select teams that are enthusiastic about VBP
- Involve motivated members and leaders to participate in the measure selection process to achieve greater success
- Identify experts early, especially those who have experience with the measures, and engage them in the selection and implementation processes

❑ **Establish an initial design for the program, including mechanisms for updating the program and its components over time**

- Form a cross-functional team to help design or refine VBP programs, overcome barriers, and establish accountability
- Determine the budget for implementing VBP or core sets
    - Consider infrastructure supports and requirements for the program, including financial resources for building infrastructure capacity, care management tools, and risk management support strategies
    - Consider additional expenditures, such as legal or collaborative fees, contract and software updates, and other increased use of resources while planning implementation efforts
    - Ensure leaders and staff have protected and funded time to work on measure implementation

- Determine the best approach to provider participation in the VBP program (e.g., voluntary or mandatory)
- Design an internal process for choosing measures and setting a strategic plan for future measurement
    - Consider whether aligned measure sets such as CQMC core measure sets should be incorporated into this process
    - See Element of Success 3: Measure Alignment for suggested considerations
- Minimize measure burden and data collection and by using measures that lead to improvements in patient care
- Recognize the amount of work necessary and address competing priorities
- Create data governance mechanisms to improve accuracy over time

❑ **Reinforce the VBP program throughout your organization for increased success**

- Incorporate measures into internal programs and priority initiatives
- Share results and successes broadly (e.g., discuss results in team meetings)
- Provide feedback on performance and strategies for improvement, making sure to also highlight successes and best practices
- Help staff and team members from your organization understand how their work feeds into and produces high quality care for patients by translating measure specifications and results into language that is relevant to their work
- Strive for commitment to high quality care as a route to high performance versus a narrow focus on measure specifics

Applying Elements of Success: Wisconsin Collaborative for Healthcare Quality
The Wisconsin Collaborative for Healthcare Quality (WCHQ) recognized the importance of an involved and motivated initiative leader who could champion their efforts early in the process. The initiative's champion helped senior leadership understand the importance of the work and gain buy-in as a result. Learn more about this use case in Appendix D.

Potential Barriers and Solutions

Lack of defined benefit for measure selection and adoption

- Compile population-level evidence to assess the conditions that pose the greatest disease burden for a defined population
- Review evidence of the measure's impact to understand the measures that have the greatest potential to improve care for the targeted population
- Incorporate this evidence into a measure selection process that prioritizes measure adoption based on community and population needs
- Recognize the importance of measure burden and be prepared to address the topic
- Use prior performances on measures to inform planning for future quality improvement initiatives

Project scope is unattainable (e.g., too large or complex)

- Separate overly large or complex projects into smaller, more attainable tasks and build on smaller initiatives over time to achieve bigger goals
- Set clear goals and communicate realistic expectations to internal stakeholders
- While processes should be standardized to some degree, allow some flexibility so that individual providers and practices can implement solutions that work best with their particular patient populations, care setting, and workflow

Suggested Tools and Resources

- Center for Healthcare Quality and Payment Reform: How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services
- Health Care Payment Learning & Action Network (HCP-LAN): Accelerating and Aligning Population-Based Payment Models
- Managing Transitions by William Bridges
- Center for Healthcare Quality & Payment Reform: How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services
- American Medical Association, Center for Healthcare Quality & Payment Reform: A Guide to Physician-Focused Alternative Payment Models
- Agency for Healthcare Research and Quality: Will It Work Here? A Decisionmaker's Guide to Adopting Innovations
- How Quality Reporting Made Me a Better Doctor
- Clinician-Directed Performance: Moving Beyond Externally Mandated Metrics
- Millbank Fund – What Makes Michigan's High-Performing Primary Care Practices Work Well?

Element of Success 2: Stakeholder Engagement and Partnership

Advancing performance measurement and payment models will require strong relationships, cooperation, and trust among internal and external stakeholders, who will need to share data and understand measure selection and measurement models. In addition, partnering with providers and other stakeholders in program design and implementation increases ownership and contributes to program success.[1,2] Stakeholders can include, but are not limited to, providers and clinicians; health systems; health plans; employers; purchaser groups; insurance brokers; patients; state Medicaid agencies; departments of health and healthcare services; colleges of public health; Quality Improvement Organizations (QIOs); and accreditation bodies, such as the National Committee for Quality Assurance (NCQA).

Implementation Considerations

❑ **Engage stakeholder partners**

- Consider including stakeholders such as providers, patients, purchasers, and others in the program design process
- Engage providers that serve patients with social risk factors to discuss strategies for improving care among vulnerable patients

- Consider creating or joining a regional collaborative or shared data analytics entity for all stakeholders
- Convene or participate in appropriate multistakeholder groups to discuss opportunities to achieve quality goals relevant across stakeholders (e.g., for blood pressure control, ensure the formulary includes the most effective options and use value-based benefit design to minimize patient barriers; provide medication adherence feedback to accountable provider)
- Explore what changes could facilitate improvements to healthcare delivery and how the design and implementation of the VBP program can support these changes
- Ask different stakeholder groups what information collected by a VBP program would be most useful to them (e.g., current performance, industry benchmarks) and in what form (e.g., dashboards, scorecards)
- Consider integrating local health agencies' community health improvement plans or local nonprofit hospital's community health needs assessment into your program
- Elevate the project visibility internally and externally to increase engagement and commitment. Stakeholders, such as association leaders, can address concerns from individual organizations in real time and can reinforce the importance of the work with members

❑ **Design or refine the VBP initiative**

- Strike a balance between flexibility and alignment in the design of the VBP program W the goal is for stakeholders to align on priorities and measures wherever possible, different stakeholders have different history and experience/technical capabilities.
    - Consider benefits offering a range of options for VBP programs and a path for progression to more sophisticated toward arrangements
    - Consider using a dry run or preview period for new or updated measures to help create provider comfort with the process and results (i.e., calculate and share results privately with providers without financial action)
        - Establish a process for addressing questions and concerns to allow all parties to work through the process without
    - Explore benefits of aligning with external stakeholders on existing and widely distributed measures (e.g., CQMC Core Sets, Healthcare Effectiveness Data and Information Set [HEDIS])
- Consider how measure results will trigger any penalties, incentives, or other financial or contractual effects

❑ **Share information to gain buy-in**

- Share what financial incentives or penalties will apply as part of entering into a new payment arrangement with internal stakeholders
- Describe the measures and methodologies used in VBP programs to providers, purchasers, and patients to gain buy-in in the program and provide visibility into the linkage between the program and high quality care
- Offer feedback and information to stakeholders in accessible and understandable formats (e.g., dashboards or scorecards) to assist with quality improvement and benchmarking efforts

Applying Elements of Success: The Alliance®
The Alliance® is a not-for-profit that partners with self-funded employers to provide healthcare coverage to employees in the state of Wisconsin. The Alliance® model is a partnership between employers and all healthcare providers to provide high value care. Learn more about this use case in Appendix D.

Potential Barriers and Solutions

Competing priorities and experience among different stakeholders may limit stakeholders from sharing their insights

- Provide educational and other opportunities to different levels of set experience and knowledge
- Bring stakeholders together with a neutral convener to set and manage expectations early in the process
- Use a consensus-based approach to engage stakeholders in the process and garner their buy-in
- Include a range of perspectives and equally share program efforts among all participants
- Partner with state government, as they are key stakeholders in the process and often play a leadership role in representing the payer community
- Balance clinician efforts with operational staff leadership and administrative support to ensure commitment is attainable
- Maintain an ongoing dialogue with stakeholders on potential means to encourage participation and partnership through:
    - Network participation
    - Financial incentives
    - Performance reports and/or datasets
    - Public reporting
    - Reduced administrative tasks

Suggested Tools and Resources

- Center for Healthcare Quality & Payment Reform: How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services
- Health Care Transformation Task Force Toolkit for Successfully Building Value-Based Partnerships
- Agency for Healthcare Research and Quality: Tools and Resources for Practice Transformation and Quality Improvement

Element of Success 3: Measure Alignment

Measure alignment is frequently identified as a key success factor for VBP programs.[2,3] Core measure sets are a promising strategy for measure alignment and the Health Care Payment & Learning Action Network recommends using core sets as sources of measures for population-based payment.[4]

Implementation Considerations

❑ **Cross-reference current measures with existing core measure sets**

- Visit the CQMC website and compare the core set measures with measures you already use
- Consider the benefits of replacing the existing non-core measures with core measures
- Prioritize core measures that offer opportunity for improvement and participation for most providers and where improvement will affect the maximum number of patients and purchasers
- Consider which measures are feasible to implement based on prior experience, available data, and technical capabilities of participants
- Develop reports that highlight successes best practices

Consider using cross-cutting measures, in addition to specialty-specific measures, to capture a large proportion of patients and care, thus decreasing the likelihood of missing results for providers due to small case numbers. See the Addressing Small Numbers and Measure Reliability section for more information.

❑ **Implement measures strategically**

- Use measures as specified to avoid misaligned measures, incomparable results, and increased measurement burden
    - Coordinate with the measure steward to access the most recent version of the specifications and check for changes to the measure over time. Measure stewards are be found through NQF's Quality Positioning System or CMS' Measure Inventory Tool
- When implementing PRO-PMs, use patient-reported outcome measure (PROM) tools and instruments as specified to avoid misaligned measures and unintended consequences (e.g., increased burden, decreased acceptance of PRO-PMs, results that cannot be aggregated) due to changing the tool or instrument without scientific testing of the potential impact on measure results
- Be ready to adapt to clinical and regulatory changes, given that quality measure specifications can lag and the updated clinical recommendation (e.g., United States Preventive Services Task Force [USPSTF] lowered the age for colorectal cancer screening from 50 to 45 in May 2021, but it took some payers time to update their quality measures)
- Consider measuring at both the clinician and facility levels, as both have an impact on quality and outcomes
- Select measures in areas that providers can directly affect and ultimately lead to improved quality and outcomes

❑ **Share feedback to inform measure development and implementation efforts**

- Provide ongoing feedback to the measure steward about the implementation of their measure(s); feedback on implementation questions and issues is a valuable resource for the measure steward
- Explore joining regional or state efforts to share feedback on the implementation process. For example, members of the CQMC use a consensus-based process to discuss, update, and

strengthen the CQMC core measure sets based on their prior experience and subject-matter expertise

Measure Developer or Measure Steward: What is the Difference?

- MEASURE DEVELOPERS: Measure developers create, edit, and submit measures to a designated steward for approval. The developer also circulates their measure content for feedback and may collaborate on potential measure changes suggested by other authors or other entities.[5]
- MEASURE STEWARDS: Stewards have permission to approve, reject, and publish measures that their assigned developer groups create and submit. Stewards provide overall coordination and management of the measures created by developers under a specific program or for a specific purpose. Stewards are responsible for approving measure content. Stewards may withdraw measures from approval.[5]
- Some measures may have both a steward and a developer, while for others, the steward and developer may be the same entity. We have used the term *measure steward* in this Implementation Guide to represent the entity with overall ownership and responsibility for the measure.[5]

Applying Elements of Success: Partnership for a Healthy Nebraska

The Partnership for a Healthy Nebraska – ALIGN measurement work aligns and prioritizes quality measurement to improve clinical quality. By utilizing a comprehensive set of measure criteria, the initiative has adopted 11 statewide measures for all payers. These 11 measures are being incorporated into both commercial and Medicaid contracts to reduce provider burden and increase the state's ability to benchmark and compare. Learn more about this use case in Appendix D.

Potential Barriers and Solutions

Limited resources constrain the ability to update existing or adopt new measures

- Analyze preliminary performance data to make informed measure selection decisions by identifying the greatest areas of opportunity
- Standardize measure collection and transmission; consider promoting dQMs to reduce the burden of participation
- Identify measures that focus on the greatest disease burden and/or identify what makes a population healthy (e.g., screenings, immunizations); these are meaningful measures for which improvement will make a significant impact on populations
- Clearly define the impact and value of measures; select evidence-based measures
- Highlight clinical reasons for why measures should be prioritized/adopted, such as health impact

Suggested Tools and Resources

- NQF: Variation in Measure Specifications: Sources and Mitigation Strategies
- Example of Success: Coalition for Compassionate Care of California
- Example of Success: MN Community Measurement

Element of Success 4: Data and Quality Improvement Support

Data sharing and quality improvement support are frequently identified as key elements of success for VBP and APM implementation.[2–4] Strategies in this section address not just how data are obtained and used to calculate measure results, but also what data are necessary for performance improvement and improving patient care and health outcomes. Data sharing can depend on the stakeholder engagement and relationships discussed earlier in this document.

Implementation Considerations

❑ **Assess what data you already have access to, and how they can be used**

- Inventory existing internal and external data assets that may be used for reporting and improvement
- Explore the use of existing Quality-Data Codes to improve consistent and interoperable collection as a way of obtaining quality data through existing claims mechanisms
- If using results from a registry, verify the registry's policies and procedures for data and results sharing to avoid any surprise restrictions on data use
    - Collaborate with registry contacts for opportunities to best utilize currently collected data
- Explore what community or regional data sources are available that are more comprehensive than internal data sources to capture care more accurately and that yield more meaningful results. Examples of data sources include APCDs, standardized data sets, and regional collaborative data warehouses

❑ **Understand what data your organization needs (or does not need) to collect**

- Do not exchange or collect more data than necessary; additional data capture that does not add value increases overhead and burden
- Consider whether it is appropriate to use existing Quality-Data Codes rather than creating additional, unique Quality-Data Codes[6]
- Focus on measures that may have the greatest impact

❑ **Establish processes to collect any additional data needed**

- Minimize clinician and patient burden by leveraging technology where possible (i.e., automate collection and capture necessary data in reportable fields and formats)
- Determine the best place in the clinical workflow to capture data and who should gather the data
- Reconcile patient identifiers with providers and streamline disease prevention and management programs, HEDIS results, and other internal quality uses via care management software

❑ **Make sure the right people get data**

- Determine who will need to receive data and when, based on the roles and responsibilities that stakeholders agreed to during program design. For example, measures may be calculated by the following parties:
    - Plans calculate measures using claims and/or raw data supplied by providers

    - Providers calculate measures with measure components (e.g., numerator, denominator, etc.) provided by the plan
    - Third party (e.g., health information exchange [HIE,] registry, data analytics partner, or regional collaborative) or vendor calculates measures
- Decide how to share data with different stakeholders
    - Data can be physically exchanged and moved among data-sharing partners, with each partner maintaining a copy of the data
    - Data can stay with the original organization, and other organizations may be granted access to the data (e.g., application programming interfaces [APIs] and HIEs)
    - Data may be submitted to a third-party organization, such as a regional collaborative or data analytics partner

❑ **Encourage and support other stakeholders building data infrastructure**

- Consider providing providers with support in collecting and receiving data
    - Consider supporting providers in establishing technological capability, both infrastructure and personnel, through innovative mechanisms, such as virtual structures (e.g., independent practice associations)
    - Create a mechanism for sharing claims information with provider groups, particularly those in a risk-bearing arrangement (e.g., provider portals and interfaces)[7]
        - Consider pushing data to providers rather than requiring them to pull data
- Explore use of electronic health records (EHRs) to support embedded core set measures
    - Validate the accuracy of reports using standard EHR analytics to avoid potential errors stemming from improper set up, insufficient training, or ongoing updates
- Share your own data for increased impact
    - Consider joining or starting a regional collaborative or other entity to create shared data resources and reporting within the community
    - Participate in pilot programs for innovative data sharing or data exchange[4]

Applying Elements of Success: Cigna
Cigna is committed to understanding and improving health outcomes for the population through measurement alignment. This may be achieved by prioritizing and adopting measures aligned on a national level and combining them with incentives at the provider level. Learn more about this use case in Appendix D.

Potential Barriers and Solutions

Data for measurement crosses sources (e.g., vaccination location other than primary care provider)

- Determine potential data sources. Often the best quality data may need to combine both claims data and clinical data from EHRs
- Consider using a shared-services (external resources) model for assistance with combining clinical data from more than one system. Data standardization and provider identity matching can be difficult and resource-intensive. Creating a shared-services model or leveraging existing external resources may be more efficient than developing a new solution.[8]
    - Consider including organizations producing public reports of healthcare quality as potential shared-service partners

    - Explore working with state agencies on data sharing opportunities. For example, the Wisconsin Department of Health Services created the Wisconsin Immunization Registry to track vaccinations, making vaccine records available to all providers and patients
    - Consider working with HIEs or regional collaboratives to fill data gaps
- Prepare to address these data-related requirements if you are in an organization working on its own to combine the clinical data[8]:
    - Patient identity management: matching patient records across the systems
    - Provider identity management: matching providers across the systems
    - Data standardization: ensuring the same data value from different sources corresponds to the same clinical meaning
- Implement an internal data governance structure, including separate agreements and governance for each data flow[8]
    - Obtain legal input early in agreement processes to address legal concerns
- Consider using the Data Use and Reciprocal Support Agreement (DURSA) in the *Tools and Resources* section as a starting point for agreements
- Leverage existing data standards such as Health Level Seven International's (HL7) Consolidated Clinical Document Architecture as appropriate to obtain data

Lack of alignment in key areas of measure adoption and implementation, including data standards, data interoperability, and data reporting specifications

- Consider aligning measures across commercial, Medicare, and Medicaid populations as possible and as meets the needs of the specific population
- Consider adopting measures recommended through national efforts, such as the CQMC core sets
- Limit measure specification modifications as much as possible
- Consider population attributes when selecting measures, recognizing that some measures will not align with the entire population
- Understand data limitations
- Ensure strong stakeholder engagement to drive the process from beginning to end
- Recognize that all organizations are unique in their approach to measure selection and implementation

Suggested Tools and Resources

- Health Care Payment Learning & Action Network guide to implementing data sharing to support VBP and APMs
- HCP-LAN Accelerating and Aligning Population-Based Payment Models: Data Sharing
- A 3D model for value-based care: The next frontier in financial incentives and relationship support
- CMS 2020 Part B Claims Reporting Quick Start Guide
- Data Use and Reciprocal Support Agreement (DURSA)

Technical Considerations for Implementation

Technical considerations may impact strategic decisions and can determine a program's success. These considerations may dictate which core measures and sets are feasible for implementation. There is currently limited public information on some topics for VBP; however, this section draws upon resources created to support public reporting of quality measures.

Benchmarking/Performance Targets

Choosing benchmarks and performance targets strategically is imperative for VBP success. Benchmark and target specifics should be discussed with stakeholders. Here we focus on potential voluntary considerations for benchmarking or setting performance targets.

Implementation Considerations

- Consider benchmarking that will reward both good performance and performance improvement.[2] If only top performers are rewarded, there may be insufficient motivation for improvement
- Consider appropriateness of initial use of incentives for sharing data or results and subsequent performance-based incentives
- Strive for program designs that reward performance improvement and facilitate sharing of best practices[4]
- Set realistic benchmarks and consider baseline room for improvement when setting targets[9]
- While benchmarks should be relevant to the group or individual being evaluated, percentiles (e.g., 50th/75th/90th) of national external performance data may provide informative data
- Performance targets should be set in absolute terms and established prior to the measurement period[2,4]
- Consider costs and benefits of various approaches (e.g., will relative targets stifle the sharing of best practices and cooperative improvement)
- Absolute benchmarks (e.g., setting a specific target performance goal) may need to be adjusted if external specifications change (e.g., if the target blood pressure in a measure is raised or lowered.) Have a plan for addressing this if it occurs
- Consider whether keeping the same targets for a longer period, (e.g., the length of the contract) may be warranted to help providers to justify investments related to quality improvement
- Results may need to be grouped and evaluated by data source if different submission methods are used (e.g., registry and electronic clinical quality measures)

Patient Attribution

Patient attribution is a methodology used to assign patients, and their quality outcomes, to providers or clinicians.[10] It is important that providers and plans share a mutual understanding of the patient attribution methodology. The methodology should be data driven and evidence based.

Implementation Strategies

- Patients may be attributed to providers prospectively or retrospectively, based on visits during the performance year. Both the plan and the provider should discuss attribution timing. The discussion should take the year-to-year stability of the patient population and plan enrollment into account.

    - Prospective attribution (i.e., attribution that happens prior to the performance year) allows providers to know their patient population prior to being measured on the treatment of that population
    - Performance year attribution (i.e., attribution that happens based on the performance year) may capture actual population and performance more accurately than prospective attribution[11]
- Understand the difference between attribution of patients for consistency with contract terms versus internal quality performance monitoring and improvement for a clinic population. Providers may want to run measures on all active patients, whereas an insurer may focus on their covered patients within a contract year
- Consider recommendations of the NQF Improving Attribution Models report, which makes the following recommendations for patient attribution[12]:
    - Use the Attribution Model Selection Guide to evaluate factors to consider in the choice of an attribution model
    - Attribution models should be tested, subject to regular multistakeholder review, and attribute care to entities that can influence care and outcomes
    - Attribution models used in mandatory public reporting or payment programs should meet the minimum criteria:
        - use transparent, clearly articulated methods that produce consistent and reproducible results
        - ensure that accountable units can meaningfully influence measured outcomes
        - use adequate sample sizes, outlier exclusion, and/or risk adjustment to fairly compare the performance of attributed units
        - undergo sufficient testing with scientific rigor at the level of accountability being measured
        - demonstrate that the data sources are sufficiently robust to support the model in fairly attributing patients/cases to entities
        - be implemented with an open and transparent adjudication process that allows for timely and meaningful appeals by measured entities

Addressing Small Numbers and Measure Reliability

Performance measures require a minimum amount of data to reliably calculate provider performance. Poor reliability may result in misclassifying performance, resulting in incorrect VBP incentives. Ground rules and parameters for reliability requirements should be part of the VBP design discussion.[13] Plans should monitor VBP programs for results that do not meet the decided-upon reliability threshold.

Implementation Strategies

- Choose area-specific measures that cover a large proportion of care delivered by a provider or cover a large patient population
- Choose measures that apply to a large percentage of providers
- Increase the percentage of care captured by including more patients (e.g., using all-payer data)
- Increase data points by extending the measurement period (e.g., measuring over a three-year period instead of one year)

- Consider using group-level results instead of clinician level, or system-level results instead of group level if unable to achieve sufficient reliability at the more granular level[14]
- Increase the signal by combining individual measure scores into a composite score. Combining scores is an advanced strategy that carries the risk of obscuring the quality signal if incorrect
- Sophisticated statistical approaches, such as hierarchical modeling and partial pooling, may be used to address small numbers. These approaches require robust statistical and computational capabilities[15]

CQMC Drivers of Change

The CQMC is in a unique position to support the voluntary alignment measures and promote measurement initiatives between public and private payers across the country. The CQMC brings together a wide variety of healthcare stakeholder groups to reach consensus on meaningful core measure sets as well as advance ongoing high-priority areas within quality measurement. The drivers of change described within this section include digital measurement, measure model alignment, and health equity; these drivers of change are intended to send a unified message to push the industry forward

Core Set Adoption

The current (2021) core sets offer an opportunity to further support measure voluntary alignment. These existing core sets are maintained (i.e., reviewed and updated) annually to reflect the changing measurement landscape, including but not limited to changes in evidence-based clinical practice guidelines, data source availability or preferences, performance gap, or risk adjustment. Clinical areas that the CQMC deems important but that do not have adequate measure representation are in the annual Analysis of Measurement Gap Areas and Measure Alignment report.

To ensure a high-caliber core set, CQMC prioritizes certain measure attributes:

- Outcome measures
- PRO-PMs
- Measures that address health equity and disparities
- dQMs
- Clinician/clinician group-level of analysis measures
- Measures that include telehealth or virtual visits

The measures in these core sets stem from a variety of different data sources. While there is wide agreement that digital measures are the future of quality measurement, current state capabilities limit providers and payers from collecting and reporting fully digital measures. Currently, the CQMC core set measures are mainly sourced from claims data (42 percent), with data from EHRs representing approximately 30 percent of measures. Other sources include registries, instrument-based data, enrollment data, and administrative data; some measures can be derived from multiple data sources. Opportunities related to data sources are in the Data and Quality Improvement Support section.

Digital Measurement

The CQMC has seen limited adoption of digital measures from its core sets due to barriers such as lack of standardized data; nonstandard approaches to data capture in clinical settings; lack of shared, low-burden technology supporting data sharing and measure calculation; and lack of incentives to adopt

digital measures. The CQMC's current digital measurement work focuses on characterizing the current environment related to digital measurement (e.g., common definitions, stakeholders, barriers to implementation, and future opportunities to promote digital measurement). This work serves as a foundation for future activities to accelerate the use of digital measures within the CQMC and the wider quality measurement ecosystem. Future roles and opportunities for the CQMC may include partnering with other organizations addressing digital measurement to explore and map data flows in detail; prioritizing measures and topic areas that are important for digital measurement; and piloting newly developed digital measures.

Measure Model Alignment

The CQMC recognizes the need to address the misalignment that exists in many aspects of both measures and the measurement process. This work highlights the need for greater alignment of measurement models used across public and private payers, as well as purchasers and other groups that rely on provider performance measurement to drive improved quality, outcomes, and affordability. The Measure Model Alignment Workgroup focuses on the development of best practices and potential policy recommendations addressing governance, structural, and operational models for payer and purchaser alignment. Further alignment could also result from a convening entity that has the capabilities and established technology model to allow for seamless data transfer between entities. To date, the CQMC has reviewed model elements and best practices from regional collaboratives and put forth options of potential regional, networked, or national approaches to engage multiple payers, purchasers, and providers in measurement alignment. Continued work in this area will focus on prioritizing model elements for alignment, innovative convening models, and identifying barriers and solutions to scale up alignment efforts to the national level.

Advancing Health Equity

Health equity is a key priority for the CQMC. The inclusion of disparities-sensitive measures within the CQMC core sets encourages stakeholders to examine and assess inequities that may exist between populations. The CQMC focuses on advancing health equity by assessing the current CQMC core set measures for disparities sensitivity and determining the role of external health equity measures and measure concepts that should be considered in future work.

Path Forward

As the U.S. healthcare system continues to move away from fee-for-service towards innovative, VBP models, quality measurement and its supporting systems must continue to evolve. It is difficult to move to bolder performance measurement when capabilities for measure implementation are limited. In parallel, it is difficult to build the required capabilities and reporting systems absent from clear and applicable cases of successful measurement strategies.

There is a need to find ways to reduce burden for clinicians and payers through making possible better alignment and reduced measure set size. The elements of success and implementation strategies included in this guide are intended to address this need and support stakeholders seeking to implement or report the CQMC core measure sets as part of VBP models. Additional areas for the CQMC to explore include using data to better identify and address population disparities, creating tools to support measure selection, and collaborating to share best practices. Stakeholders can learn from examples of

successful measure implementation and can scale feasible solutions to achieve broader measure alignment.

The CQMC continues to convene stakeholders to provide guidance on measurement alignment across public and private payers and to drive improvement in the quality of healthcare for all Americans. To support successful core set adoption, the CQMC is prioritizing efforts to advance a digital measure-reporting infrastructure and provide guidance on identifying and reducing health disparities. Working together, healthcare stakeholders can strengthen and align quality measurement to advance value-based care and achieve favorable population health outcomes.

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Appendix A: Tools and Resources

Element of Success 1: Leadership and Planning

- Center for Healthcare Quality and Payment Reform: How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services
- Health Care Payment Learning & Action Network (HCP-LAN): Accelerating and Aligning Population-Based Payment Models
- Managing Transitions by William Bridges
- Center for Healthcare Quality & Payment Reform: How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services
- American Medical Association, Center for Healthcare Quality & Payment Reform: A Guide to Physician-Focused Alternative Payment Models
- Agency for Healthcare Research and Quality: Will It Work Here? A Decisionmaker's Guide to Adopting Innovations
- How Quality Reporting Made Me a Better Doctor
- Clinician-Directed Performance: Moving Beyond Externally Mandated Metrics
- Millbank Fund – What Makes Michigan's High-Performing Primary Care Practices Work Well?

Element of Success 2: Stakeholder Engagement and Partnership

- Center for Healthcare Quality & Payment Reform: How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services
- Health Care Transformation Task Force Toolkit for Successfully Building Value-Based Partnerships
- Agency for Healthcare Research and Quality: Tools and Resources for Practice Transformation and Quality Improvement

Element of Success 3: Measure Alignment

- NQF: Variation in Measure Specifications: Sources and Mitigation Strategies
- Coalition for Compassionate Care of California
- Minnesota Community Measurement

Element of Success 4: Data and Quality Improvement Support

- Health Care Payment Learning & Action Network guide to implementing data sharing to support VBP and APMs
- HCP-LAN Accelerating and Aligning Population-Based Payment Models: Data Sharing
- A 3D model for value-based care: The next frontier in financial incentives and relationship support
- CMS 2020 Part B Claims Reporting Quick Start Guide
- Data Use and Reciprocal Support Agreement (DURSA)

Appendix B: Reviewing Measure Specifications

This section is based on the Centers for Medicare & Medicaid Services' (CMS) Measure Management System Blueprint.[5]

Measure specifications are technical instructions for how to build and calculate a measure. Measure specifications are available from the measure steward. The measure steward creates and maintains the measure. Measure stewards are included in the measure information published for the CQMC core sets. Review the measure specifications early in the project to determine where and how to obtain the data and information to calculate the measure. Include the multistakeholder team in the review to surface any concerns or questions.

Data Source

What data are used to calculate the measure? It may be possible to calculate a measure from more than one source. For instance, a measure might be calculated using a registry or using medical records. Results from different data sources may not be directly comparable.

Examples of data sources include the following:

- Administrative data
- Claims data
- Patient medical records: paper and electronic
- Electronic clinical data, such as device data
- Registries
- Standardized patient assessments
- Patient-reported data and surveys

Denominator

What population will be evaluated by the measure? The denominator statement includes parameters such as:

- Age ranges;
- Settings;
- Diagnosis;
- Procedures;
- Time interval; and
- Other qualifying events.

Format—Patients, age [age or age range], with [condition] in [setting] during [time frame]

Example: Patients 18-75 years of age by the end of the measurement year, who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year (NQF #0062).

Denominator Exclusion

Denominator exclusions define patients that should be removed from the denominator prior to calculating the measure.

Format of the exclusion statement—Denominator-eligible patients who [have some additional characteristic, condition, procedure]

Exclusions

Are there patients to whom the measure does *not* apply?

Format of the exclusion statement—Denominator-eligible patients who [have some additional characteristic, condition, procedure]

One example of an exclusion is a screening mammography for a woman who had a bilateral mastectomy.

Numerator

What population meets the intent of the measure? The numerator statement includes parameters such as:

- The event or events that will satisfy the numerator requirement; and
- The performance period or time interval in which the numerator event must occur, if it is different from that used for identifying the denominator.

Format—Patients who received/had [measure focus] {during [time frame] if different than for target population}

Example: Patients receiving a nephropathy screening or monitoring test or having evidence of nephropathy during the measurement year (NQF #0062).

Exceptions

Are there patients for whom clinical judgement might reasonably result in not meeting the intent of the measure? When calculating the measure, logic needs to be implemented for when to search for exceptions, as outlined in the example below.

Example: Asthma can be an allowable denominator exception for the performance measure of the use of beta blockers for patients with heart failure. Thus, physician judgment may determine there is a greater benefit for the patient to receive this treatment for heart failure than the risk of a problem occurring due to the patient's coexisting condition of asthma. Because the medication was given, the measure implementer does not search for exceptions, and the patient remains in the denominator. If the medication is not given, the implementer looks for exceptions and removes the patient, in this example a patient with asthma, from the denominator. If the medication was not given and the patient does not have any exceptions, the patient remains in the denominator and the provider fails the measure.

Level of Analysis

What entity or entities is the measure intended to measure? Unless otherwise noted, all measures in the CQMC core sets are at the clinician-group and/or individual-clinician level of analysis. This means they are specified and tested for use only at these levels of analysis.

Risk Adjustment Methodology

Some measures need to be adjusted for factors outside the control of the measured entity to ensure measure differences reflect differences in care. The risk adjustment model and methodology should be fully described in the measure documents.

Calculation Algorithm

How are the measure elements used to calculate the measure? In what order are steps performed? If the team has any questions or this is not clear, reach out to the measure steward for clarification.

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Appendix D. Use Cases

Wisconsin Collaborative for Healthcare Quality – Regional Collaborative

The Wisconsin Collaborative for Healthcare Quality (WCHQ) was founded in 2003, with the goal of improving the health of individuals and communities through meaningful performance measurement that improves the quality and affordability of healthcare in Wisconsin. WCHQ is a membership organization and includes stakeholders such as health systems and providers, dental practices, and payers. WCHQ develops, collects, and publicly reports quality information across the state. In addition to public reporting, WCHQ creates and disseminates quality improvement strategies, reports, and best practices across member organizations.

Measure Selection Insights and Experiences

WCHQ's improvement model is to collect patient-level data, compare measurements, work with members to identify best practices, disseminate these best practices, and create or adopt new measures. WCHQ publicly reports measurement results at the health system and clinic levels, providing statewide benchmarks. WCHQ measures can be used to create incentive programs but are designed primarily for transparency and quality improvement purposes. WCHQ and member organizations look to National Quality Forum (NQF,) the CQMC, and the National Committee for Quality Assurance (NCQA) for opportunities to align while also considering unique, regional aspects of care.

Strategies for success include the following:

- **Identify a champion who can lead the effort.**
- **Strong support for the measure/measure category in the form of evidence and stakeholder support is necessary.**
- **The measure goal must be clear.**

Lessons Learned

- The involvement of motivated members and leaders who participate in the measure selection process are important to success.
- It is important to identify experts early in the process. Experts who have experience with the measure are assets in the selection and implementation processes.
- Time is a key factor. The processes of selection and implementation take time and should not be rushed.
- Do not underestimate measure burden. Stakeholders will challenge measures if there is a perception that documentation and data collection are time consuming, and the information does not inform improvements in patient care.
- Recognize the amount of work necessary and address competing priorities. Selecting and implementing measures is a lengthy and resource-intensive process. As the work unfolds, competing priorities may become a challenge for team members.

Future Direction

- Explore and address state-level disparities through partnerships and expanded data collection
- Look at the role of both quality and cost to measure value across organizations

The Alliance® – Employer/Purchaser

The Alliance® is a not-for-profit cooperative of self-funded employers in Wisconsin focused on shared health purchasing. The Alliance provides resources for planning, design, and analysis through a variety of tools, including measure recommendations and implementation support. The Alliance's QualityPath® program (Figure 1) identifies doctors and hospitals that—when working together—meet national quality measures and adopt processes that are better for patients.

Figure 1. The Alliance - QualityPath® Key Concepts & Requirements for Provider Participation

Measure Selection Insights and Experiences

The Alliance began quality and measure assessment work over a decade ago, with the goal of approaching measurement from a payer perspective and to ultimately drive patients to high quality providers through measurement reporting.

Early on, the measurement selection process focused on identifying measures associated with high-cost conditions and procedures as well as measures that could result in a care shift to high quality providers or facilities.

Lessons Learned

- Measure implementers should be flexible to adapt to industry changes. As an increasing number of patients shifted to outpatient settings, the Alliance realized the original measures selected with an inpatient focus were not adaptable to the outpatient setting and needed to be retired or modified.
- Original selection criteria were not applicable to all settings. The early measure selection criteria were focused on measures that would encourage patients to seek care in high quality

settings. However, the Alliance found that in certain instances, patients were unwilling to change locations or providers. Distance-to-travel and specialty were factors that affected some patients' desire to change.
- Measure at both the provider and facility levels. Both analysis levels matter and have an impact on quality and outcomes.
- Prioritize selecting measures reported at the provider level to align with how patients make care decisions (e.g., patients often choose a preferred physician when seeking care).

Future Direction

- Leverage new data sources to support measurement scalability.
- Move from voluntary to mandatory participation.
- Identify new measures in gap areas, such as primary care and elective musculoskeletal areas.
- Better measures are needed to assess the appropriateness of care.

Kentuckiana Health Collaborative – Regional Collaborative

The Kentuckiana Health Collaborative (KHC) is a nonprofit, purchaser-led, multistakeholder coalition spanning Southern Indiana (IN) and Kentucky (KY). Member organizations include a variety of stakeholders, such as health systems, providers, hospitals, health plans, employers, public health and government, labor unions, consumer advocacy groups, pharmaceutical companies, and others. KHC works with members to gather data from health plans, such as HEDIS indicators, to populate annual quality measurement reports to share with providers, group practices, and the community. To encourage alignment between both the private and public sectors, KHC has coordinated and aligned with both the state Medicaid (both KN and IN) office and private payers since 2017 to create a core measure set.

KHC's measurement work is focused in two areas: measure alignment/prioritization and quality reporting. The quality reporting is completed through the dissemination of Consolidated Measurement Reports, which allow members to compare local averages, state averages, and benchmarked quality scores on a variety of ambulatory measures. These reports combine commercial, Medicaid, and Medicare Advantage data.

Measure Selection Insights and Experiences

The 42 primary care measures in the KY Core Healthcare Measures Set (KCHMS), first developed in 2017 and updated every other year, closely align with the CQMC core set measures. The process for evaluating and selecting measures is a multistakeholder and consensus-driven process organized by subcommittee and aligned by measure area. Each subcommittee uses tools during its measure selection process, including a crosswalk of measures for measure alignment, a rubric for scoring and prioritizing, and a set of measure selection criteria for initial selection. The measure selection criteria are as follows:

- The measure set is of manageable size.
- Measures are based on readily available data in KY (we must identify the data source), such as HEDIS measures.
- Preference is given to nationally vetted measures (e.g., NQF-endorsed) and aligned to Medicaid and Merit-Based Incentive Payment System [MIPS] measurement sets.

- Each measure should be both valid and reliable and produce sufficient numerator and denominator size to support credible public reporting.
- Measures target issues that we believe have significant potential to improve health system performance in a way that will positively affect health outcomes and reduce costs without unintended harm.
- If the unit of analysis includes healthcare providers, the measure should be amenable to influence by providers.
- The measure set is usable by multiple parties (e.g., payers, provider organizations, public health, communities, and/or policymakers).

Measures are deemed "high priority" if the subcommittee concludes that a measure area is a high driver of health and/or cost and there is overall support for the measure.

Lessons Learned

- Set expectations and allow the process to work. The process itself can be lengthy, but it is worth the time and effort.
- Be realistic and manage stakeholder expectations. Stakeholders may have unrealistic expectations regarding measures that may impede the process.
- Acknowledge the challenge of reporting early on. Data availability and resource constraints lead to reporting challenges that must be addressed during the measure selection process.
- A multistakeholder, consensus-based process will achieve the greatest results and lead to a high level of engagement from subcommittee members.
- Include the right partners at the table and broad stakeholder representation**.** To achieve successful alignment and a low level of burden, all stakeholders must be present and engaged.
- State partners are key to alignment success. At the state level, partners such as Medicaid often take a leadership role among the payer community.

Future Direction

- Continue to review the recommended measures and work towards a smaller, more parsimonious measure list.
- Strive to report on all recommended measures in the core sets.
- Achieve stakeholder alignment to use measures for value-based contracting.

ALIGN/Partnership for a Healthy Nebraska – Community Non-Profit

Partnership for a Healthy Nebraska is a non-profit focused on collaboration to improve the health of people living and working in Nebraska. Part of this work is to improve patient outcomes through efforts to streamline and standardize clinical processes, including the alignment of quality measures and improving population health outcomes.

Measure Selection Insights and Experiences

As part of the ALIGN coalition, Partnership for a Healthy Nebraska and the University of Nebraska Medical Center College of Public Health engaged Nebraska Payers (both Commercial and Medicaid) as well as healthcare organizations (including ACOs, hospitals, and safety net providers) to adopt a core set of 11 measures for statewide alignment across all payers. Measure selection criteria focused on high value, high-impact, and evidence-based measures. In addition, a rank-based process was used based on

committee member's individual perception of measure importance. Ten measures were initially selected through this process, but an eleventh 11th measure was added based on the areas where Nebraska ranked low on America's Health Rankings.

Category	ALIGN Measure	NQF*	HEDIS
Adult	Diabetes: Hemoglobin A1c (HbA1c) Poor control (>9%)	0059	HBD
-	Hypertension Control <140/90	0018	CBP
-	Colorectal Cancer Screening	0034	COL
-	Breast Cancer Screening	2372	BCS
Pediatric	Immunization 0-2 years, Combo 10 (DtaP, IPV, MMR HiB, HepB, VZV, PCV, HepA, RV, Flu)	0038	CIS
-	Immunization Adolescents, Combo 2 (HPV, Tdap, Meningitis)	1407	IMA
-	Well Child Checks (0-30 months)	1392	W30
Maternal	Prenatal and Postpartum Care	α 1517	α PPC
-	Perinatal Depression Screening	+ 1401	ɣ β
Behavioral Health	Unhealthy Alcohol Use: Screening and Brief Counseling	2152	ASF-E
-	Depression Screening (ages 12+)	0418	β DSF

Cells marked by a dash (-) are intentionally left blank.

* NQF definitions are used by federal programs, such as Medicare/Medicaid, unless otherwise noted.

◇ The Centers for Medicare & Medicaid Services (CMS) measure is still for Well child checks 0-15 months. The HEDIS W30 measure is on page 14 of the document linked in the table above.

α This is a combination measure with two components: Timeliness of prenatal care and postpartum care follow-up. Both CMS and HEDIS use this combined definition.

+ Not currently in use by any federal programs

ɣ There are two separate HEDIS measures for perinatal depression: prenatal (**PND**) and postpartum (**PDS**).

β The HEDIS behavioral health measures are part of the "measures reported using electronic clinical data systems" that are being introduced (but not fully implemented yet)).

Strategies for success:

- **The coalition addressed a common sense of frustration regarding a lack of alignment to help engage all stakeholders early in the process.**
- **Started with a neutral convener, Dr. Ali Khan, Dean of the College of Public Health.**
- **Emphasized that measures should align across domains and improve population health while also reducing measurement burden.**
- **The Overarching goal from the very beginning was to prioritize and identify a small group of measures that could reverse Nebraska's multi-decade slide in America's Health Rankings.**
- **Reporting focuses on highlighting high performers among clinics and ACOs, then sharing best practices.**

Lessons Learned

A measure selection process should set limits to avoid the inclusion of too many measures. Identifying criteria allowed the selection committee to focus on measures that are important to the success of the

effort. It is essential to engage clinicians, which can be accomplished by identifying a measure's impact on patient care and population health and aligning measures with payment and reimbursement.

Future Direction

The 11 ALIGN measures are already incorporated in Medicare ACO contracts and the new Primary Care First program from the Center for Medicare & Medicaid Innovation (CMMI.) They are also being added to Blue Cross Blue Shield Nebraska's Total Cost of Care contracts, and Nebraska Medicaid is incorporating the measures in the updates to its Medicaid Managed Care contracts. The coalition's next goal is to engage both employers and other commercial health plans.

Cigna – Health Plan

Cigna is a leader in utilizing comprehensive measure sets to better understand value for its populations. Cigna uses nationally recognized measures from those endorsed by NQF, NCQA HEDIS, and the CQMC.

Measure Selection Insights and Experiences

Cigna utilizes measures to build and expand its programs with aligned incentives for network providers. Currently, most measures included in Cigna's ACO measure set are from the ACO/PCMH/Primary Care CQMC core set. These measures are organized into two buckets: evidence-based measures and patient experience.

Lessons Learned

- Avoid changing measures unless there is a clinical reason.
- Be aware of barriers to operationalizing measures.
- Focus on measures that have an opportunity for high success and can be tied to financial incentives for clinicians.
- Recognize that there is a trade-off between uniformity and burden.
- Policy has a role to play in moving measurement forward.

Future Direction

- Continue to work toward a small measure set.
- Move toward digital measures by engaging vendors and addressing data source challenges.
- Focus on alignment between insurance carriers, medical specialty societies, and providers to reduce noise.
- Work toward measures that meaningfully improve quality and affordability for patients.

Additional Use Cases Related to Data Collection

Minnesota Community Measurement – Collecting Race, Ethnicity, and Language Data

Minnesota Community Measurement (MNCM) has been tracking how to collect race, ethnicity, and language data and documented this information in the Handbook in the Collection of Race/Ethnicity/Language Data in Medical Groups published in 2009. This handbook:

- defines and standardizes the data elements to be collected by healthcare entities;
- identifies and recommends additional data elements for collection to improve care given within the medical group setting;

- provides insights and lessons learned from several medical groups with experience in collecting these data; and
- serves as a resource and provides support to those who will lead these initiatives in medical groups across the state.

Since the publication of its Handbook, MNCM has been working across the state to support standardized data collection at the medical-group level. MNCM has identified a set of best practices for data collection and the use of these data in quality measurement to help providers better understand patient populations and identify disparities.

MNCM's best practice strategies for collecting race, ethnicity, and language preference data include the following:

- **Collect data directly from the patient**
- **Include distinct race categories that can be combined into a multiracial category instead of including a multiracial standalone option**
- **Strive for completeness as much as possible**

MNCM's use of race, Hispanic ethnicity, preferred language, and country of origin (RELC) was initially reported privately to medical groups with a plan to incorporate it into public reporting when at least 60 percent of practices were demonstrating best practice in the collection of RELC data from the patient. This threshold was met after several reporting cycles. Since then, MNCM has been stratifying results for clinical quality measures to understand gaps in care and potential opportunities within race/ethnicity categories.

Future Direction

MNCM has utilized its data to stratify quality measurement reporting, supporting the identification of opportunities for improvement and resource allocation. Figure 1 demonstrates disparities among several components of a composite measure for diabetes care in which Indigenous/Native American and Black patients have significantly lower rates of achieving component goals when compared to the general population. MNCM hopes to expand this approach to other measurement areas in the future.

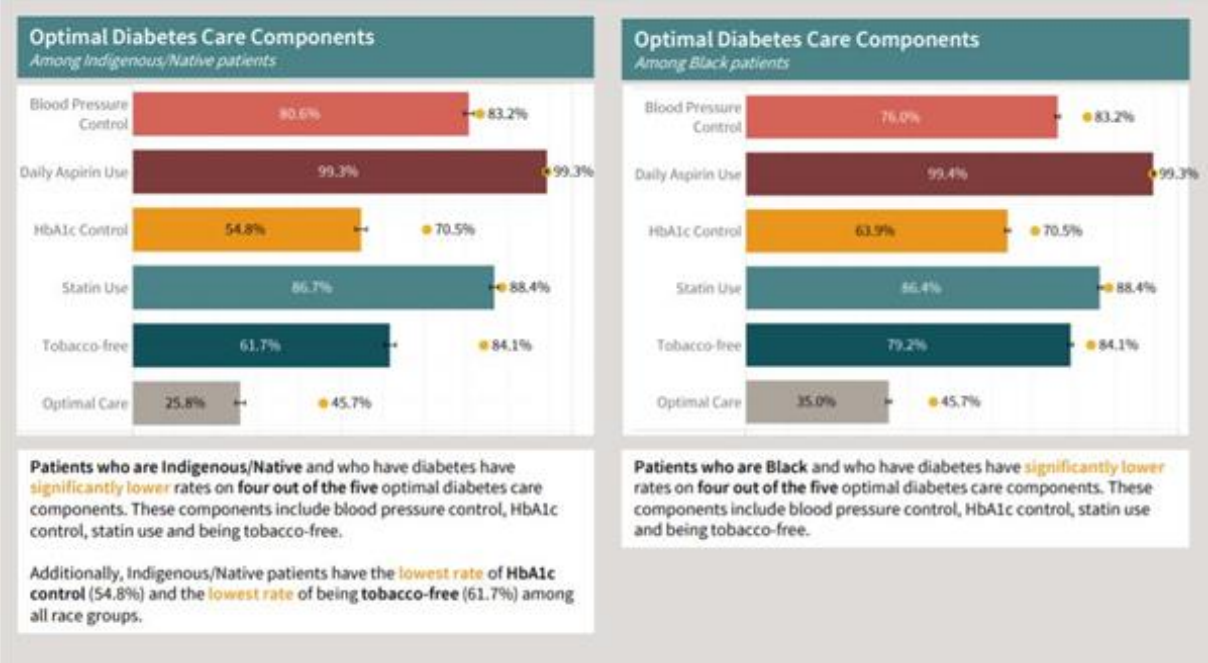

Figure 2. Minnesota Community Measurement Optimal Diabetes Care Components Among Indigenous/Native and Black Patients

Aetna – Collecting Race, Ethnicity and Language Data

Aetna has collected race, language preference, and ethnicity data from over 6 million members for over a decade and uses these data to identify opportunities to address inequities. Aetna has started to use these data to address disparities on asthma emergency room (ER) utilization, assess ethnic disparities in breast health, and develop a racial and ethnic equality dashboard. Aetna believes that collecting these data and using them to improve outcomes is the only way an organization can be successful.

Aetna's best practices for data collection include the following:

- **Collecting race, language preference, and ethnicity data consistently and broadly at the provider level**
- **Using the data to understand the needs and challenges of a patient population**
- **Understanding how these data can support a deeper knowledge of a patient's culture and the role culture plays in care and treatment**
- **Working with providers to use the information where it matters—at the patient level**
- **Payer understanding that providers may need support to apply analytics at the patient level**

Future Direction

Aetna believes that using race, ethnicity, and language preference is an important step to understanding patients better and achieving improved outcomes. The next step in the journey is to utilize a similar process with social determinants of health (SDOH). Aetna has begun to explore population health through an SDOH index. The table below correlates socioeconomic status (SES) risk by six indices (Figure 2). Aetna uses this index to stratify population groups for planning and identifying improvement opportunities.

Humana – Collecting Data on Social Determinants of Health and Health-Related Social Needs

Humana's focus on health equity and SDOH uses a comprehensive approach to identify factors related to disparities and equitable care. In addition to evaluating factors such as race and ethnicity, Humana has prioritized the collection and analysis of data on member SDOH and health-related social needs (HRSNs). This includes using both aggregated, geographic-level, SDOH data, such as data from the U.S. Census Bureau or the Robert Wood Johnson Foundation's (RWJF)County Health Rankings, and member self-reported HRSNs, such as food insecurity and loneliness.

By incorporating HRSN screenings into member outreach and care models, Humana is able to include social health in the member longitudinal health record. In addition, with the greater breadth of SDOH and HRSN data incorporated into the organization's data lake (i.e., centralized data repository), Humana has leveraged artificial intelligence to develop new predictive models and segmentation in order to better identify and address member needs and health disparities. A social risk index, generated for each member utilizing a combination of neighborhood- and patient-level social risk data, is also used to identify members at high social risk and to prioritize them for screening and interventions. It may also be the basis of new, innovative payment models to align incentives to focus care and resources on socially fragile populations.

Humana's approach to data collection includes the following:

- **Alignment on data standards to ensure interoperability and validity**
- **Ensuring appropriate data governance policies and secure storage are in place to protect member privacy and ensure ethical use of data**
- **Refinement of data collection methodology and use that is member-centric, builds trust, and provides a positive member experience**

Future Direction

Humana continues to refine and improve the process for race and ethnicity data collection and storage and intends to use these data to better understand the areas in which disparities exist for current clinical quality measures, patient experience measures, and member outcomes. In addition, Humana will work to identify the contributing factors that play a role in these disparities. Humana's future data collection, in collaboration with regulatory, quality, and accreditation entities, will focus on sexual orientation and gender identification while continuing to improve current data collection for factors such as preferred language and disability status.