Approaches to Core Set Prioritization

Background

Transforming healthcare payment from volume to value requires quality, patient experience, and efficiency metrics to assess the success of the models and their participants. The increased reliance on performance measures as part of these models led to a proliferation of measures and a commensurate increase in burden on providers collecting the data, confusion among consumers and purchasers seeing conflicting measure results, and operational difficulties among public and private health insurance providers.

The Core Quality Measure 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 and 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 American healthcare. The CQMC is a voluntary effort in which members choose to participate and subsequently promote adoption of the core measures.

The goals of the CQMC are to:

- Identify high-value, high-impact, evidence-based measures that promote better patient outcomes, and provide useful information for improvement, decision-making and outcomes-based payment.
- Align measures across public and private health insurance providers to achieve congruence in the measures being used for quality improvement, transparency, and payment purposes.
- Reduce the burden of measurement by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and reporting requirements across public and private health insurance providers.

The CQMC will accomplish these goals through the development and implementation of core measure sets. The CQMC defines a core measure set as a parsimonious group of scientifically sound measures that efficiently promote a patient-centered assessment of performance specific to a particular clinical area or care approach. Value-based purchasing (VBP) and alternative payment models (APMs) should prioritize the inclusion of measures in the core sets.

The CQMC initially developed eight core sets in areas identified as high priority by its members. To develop these sets, the CQMC split into workgroups. Each workgroup reviewed measures currently in use by CMS and health plans, measures endorsed by the National Quality Forum (NQF), and measures recommended for discussion by CQMC members. Based on this review and discussion the workgroups

identified a consensus core set for the selected clinical areas. The consensus core sets were then discussed by the Steering Committee and the full CQMC before being finalized. The eight sets are:

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

The CQMC will continue its work through ongoing maintenance of these existing core measure sets every two years to reflect the changing measurement landscape, including, but not limited to, changes in evidence-based clinical practice guidelines, data sources, or risk adjustment. It further seeks to expand into new topic areas not yet addressed. In addition, the CQMC seeks to identify gaps in measurement and challenges in implementation in order to advance adoption of the core sets.

Prioritization of Topics for New Core Sets

The CQMC aims to identify the most meaningful healthcare performance measures and prioritize them for implementation. However, multiple stakeholders use performance measures, and those stakeholders may have varying perspectives on the goals and priorities for measurement. The potential for differing stakeholder views highlights the need for a thoughtful and consensus-based approach to the selection of topics for the creation of additional core sets.

To date the CQMC has chosen to focus on clinician measurement, primarily in the ambulatory care setting, and to identify measure sets that could support multiple care delivery models. Meeting the needs of multiple stakeholders for multiple applications of measurement (such as public reporting, provider feedback reports, or VBP) will be a difficult task. It is unrealistic to expect the core sets to cover every possible scenario for every stakeholder, rather the goal should be to prioritize in a way to maximize value for CQMC members and stakeholders.

The CQMC should consider these factors in prioritizing measure sets:

1. Prevalence: Does the proposed topic address a high-prevalence area? Is the condition or area relevant to a significant number of patients or a large population?
2. Impact on cost of care: Does the proposed topic represent an area of high healthcare spending? Is there variation in cost? Could improvement result in lower healthcare costs or more efficient care? Is there an opportunity to improve measure alignment across programs in the topic area to reduce burden and improve efficiency?
3. Relevance to membership: Is the proposed topic relevant to a significant portion of the CQMC membership? Does the topic address an area of concern to many health insurance providers? Is the topic relevant to different types of clinical organizations? Does CQMC membership include expertise on the topic?

4. Opportunity for improvement: Is there known variation in outcomes of interest for the topic area? Is there a gap between current performance and optimal performance? Are there disparities in care relevant to the topic area?
5. Feasibility: Does the topic area have relevant measures available?

These factors could be incorporated into a quantitative ranking of proposed core sets resulting in a prioritized list. The factors could also be used by CQMC members to create a prioritized list through CQMC member vote or consensus opinion. These factors and decision-making methods would work with the existing approach of specialty- and condition-based sets or could be expanded to other types of topics (for example, cross-cutting topic areas such as safety or patient experience).

These factors should also be used to weigh the expansion of current core sets (e.g., expanding medical oncology to include surgical oncology or radiation oncology or expanding to additional levels of analysis) versus new core set development. Expansion of a current set may not require the need for the formation of a new workgroup, while creating a new set in a new area requires the involvement of the relevant clinical experts.

Previously, to facilitate the CQMC's decision about how to prioritize areas for additional core sets, NQF developed potential approaches to prioritizing new topics. To guide this effort, NQF staff conducted an environmental scan of approaches used by other initiatives seeking to develop core sets, as well as identified conditions that have high incidence or prevalence or high healthcare spending and would benefit from increased measure alignment to drive coordinated improvement in key areas while minimizing provider burden. This work aligns with CMS' Meaningful Measures Initiative. A review of the approaches used by organizations referenced in the environmental scan illuminates several considerations for determining topics for the development of new core sets. Each consideration has strengths and weaknesses, and some may be more suited to particular measurement applications than others.

The CQMC utilized the information previously gathered to identify Behavioral Health and Neurology as the next core sets for development. Below are examples of potential conditions and factors the CQMC could consider for development in future years.

- Pulmonary (examples include asthma and Chronic Obstructive Pulmonary Disease (COPD))
    - Approximate cost: The direct costs of asthma were estimated at $50.1 billion a year in 2011.[1] The total cost of asthma (including absenteeism and mortality) was $81.9 billion in 2013.[2] Costs attributable to COPD were estimated at $32.1 billion in 2010 with national medical costs projected to increase to $49.0 billion in 2020.[3]
    - Impact: 8.3 percent of Americans have asthma,[4] and more than 11 million Americans are diagnosed with COPD, based on a 2017 estimate.[5]
    - Measure availability: NQF's current portfolio includes 12 endorsed measures that address aspects of asthma care and 16 measures focused on care for COPD.
- Endocrine (diabetes, for example)
    - Approximate cost: The direct costs of diabetes were estimated at $237 billion in 2017, while indirect costs totaled $90 billion.[6] Another study estimated the cost of diabetes, urogenital, blood, and endocrine disorders at $224.5 billion in 2013, with diabetes costs totaling $101.4 billion.[7]

    - Impact: In 2015, it was estimated that 9.4 percent of the US population had diabetes and 33.9 percent of U.S. adults had prediabetes.[8]
    - Measure availability: The NQF portfolio includes 21 endorsed measures addressing endocrine conditions. The majority focus on diabetes care.
- Emergency Medicine
    - Approximate cost: A 2016 study estimates that more than 1 in 10 health care dollars in the US is spent on emergency department episodes of care.[9]
    - Impact: In the US in 2016, there were 145.6 million emergency department visits. [10]
    - Measure availability: NQF has approximately 20 measures related to care delivered in the emergency department, though few of these measures are at the clinician level. The Merit-based Incentive Payment System (MIPS) uses several other measures in this category that could be considered.
- Geriatrics (for example chronic conditions and impairments, polypharmacy, and quality of life in the elderly)
    - Approximate cost: According to a 2015 study of medical costs in the U.S. elderly, individuals in the top 5 percent of the distribution of total expenditures spend about $98,000 per year, nearly seven times the overall average of $14,000 and accounting for 35 percent of all medical spending.[11]
    - Impact: In 2016, 15.2% of the population was over 65 years, and it is estimated that approximately 60% of older adults have 2 or more chronic conditions.[12], [13]
    - Measure availability: There are over 80 NQF-endorsed measures that focus on care for elderly patients in the outpatient setting.

Environmental Scan Findings

NQF searched for efforts by other groups that are developing or have developed core sets of measures or that have identified principles for a core set. NQF initially identified 18 initiatives. These initiatives were included if they had publicly available information describing why their core set topics were selected and/or how they were prioritized. Efforts that established principles for measure selection but did not create specific sets of measures were excluded. Twelve national and state efforts fit the inclusion criteria for this scan. NQF assessed the initiatives' rationales for selecting certain focus areas for their core sets and categorized each initiative by the approach used. A summary of each effort identified, and its prioritization approach is included in Appendix A.

Some themes arose across the efforts. The majority of efforts created core sets in response to a specific need or requirement such as legislation or as part of work undertaken as awardees of the State Innovation Models (SIM) Initiative. [14] Some efforts focused on creating one core set of measures to address a specific purpose (e.g., for use in ACOs) while others have created multiple sets addressing different topics (e.g., a set of measures to include in hospital contracts and a different set to include in clinician contracts).

The scan revealed five general approaches to identifying topics for core sets:

1. Stakeholder priorities: Core set topics were chosen based on the priorities of the stakeholders involved in the core set creation.
2. Cross-cutting topics (e.g., apply to multiple conditions, settings, or models): Core sets were chosen to address cross-cutting topics of interest.
3. Purpose specific: Core sets were developed for a specific purpose, such as supporting a payment

model or measuring the impact of an initiative or change.

4. Setting specific: Core sets were chosen to evaluate care in a specific setting, such as a hospital or an ambulatory clinic.
5. Specialty specific (current CQMC approach): Core sets were chosen to evaluate care provided by a specific specialty.

Additional Considerations for the Creation of Core Sets

Identifying Topics by Condition/Specialty

The CQMC currently focuses on core sets that address specific conditions or medical specialties. Continuing this focus on clinical condition or specialty area has many benefits, including maintaining momentum. This approach allows the CQMC to focus on the conditions of interest to its members (e.g., high cost to payers/purchasers, alignment with CQMC member expertise, conditions that have high impact on patient quality of life). This approach allows for the creation of core sets that users can apply in multiple payment or delivery models, including reporting and VBP programs. This approach does not negate a focus on cross-cutting topics, as the principles for measure selection include a criterion that promotes consideration of key cross-cutting areas for measurement. Including these measures in condition-specific sets could help highlight the need for adoption of these measures. For example, if measures addressing disparities are in the cardiovascular core set rather than in a separate disparities core set, they may be prioritized for implementation. This approach also allows the CQMC to capitalize on the expertise of its members and could support maximum buy-in across stakeholders as clinicians may feel a greater degree of control over measures in their specialty.

However, continuing with this approach has limitations. First, focusing on certain conditions may limit the ability to include all-cause or all-condition measures in the core sets. This approach could also potentially limit the impact of CQMC efforts outside of targeted clinical areas. Certain conditions may be of utmost interest to some CQMC members, but less relevant to others. The sets may not align closely with the continuum of care for patients, especially patients who are complex, who lack a diagnosis, who have a condition with more than one possible care path, or who may have more than one specialty involved in their care. Use of specialty- or condition-focused measure sets for quality improvement may encourage an isolated approach to quality improvement over a system approach. Focusing on specific clinical areas could limit the ability of some members to participate in new core set creation and to use the new core sets, and it may risk alienating members who have a broader focus. Finally, measures may not be available or in wide use for the conditions of interest to the CQMC.

If the CQMC continues this approach, the resulting CQMC core set could reduce some of the existing gaps in high-impact, high-cost conditions. The CQMC could solicit potential topic areas from all members and provide additional information to guide the CQMC's prioritization decision. CQMC members have expressed interest in sets for emergency medicine, geriatrics, and palliative care. Some CQMC members also expressed interest in expanding the current core sets to include related clinical areas (e.g., the medical oncology set could expand to "oncology" and include measures for radiation and/or surgical oncology). There was also some interest in focusing on maternal health, potentially as expansion related the OB/GYN core set, as well as ambulatory surgery.

Identifying Topics by Cross-Cutting Areas

The majority of efforts revealed by the scan identified core sets for use in specific delivery models or to assess quality of care in a specific setting or specialty. However, another option would be to focus future

core sets on specific goals or priorities that cut across care settings and practice areas. For example, the Measure Applications Partnership (MAP) identified measure families to help highlight gaps in cross-cutting areas. CMS has developed the Meaningful Measures framework to identify Meaningful Measure Areas to connect measures to strategic goals. Examples of cross-cutting topic areas include care coordination/transitions of care, patient safety, access to care, appropriate use, or population health. CQMC members have also expressed interest in measures related to diagnostic quality and safety, though further measure development is needed in this area.

Identifying topics by cross-cutting areas offers potential benefits. First, creating core sets using this approach could allow for a more holistic view of quality by focusing on key elements of care not necessarily addressed in condition-specific measures. Moreover, this approach could highlight the importance of these topics in improving healthcare quality. This approach could also allow for an assessment of care across settings and providers, and over time, as well as allow for the inclusion of broader measures (e.g., all-cause or all-condition) which may not align well with the CQMC's current framework. The broad coverage and applicability across settings and providers could yield information useful to a wide variety of patients in many situations. This approach could also help reduce measurement burden, as measures are broadly applicable across multiple providers and specialties.

Drawbacks to creating sets for cross-cutting areas also exist. Placing cross-cutting measures in separate sets risks isolating important concepts like patient experience, disparities, and safety rather than integrating them into various clinical topic areas as central elements. In addition, the CQMC has highlighted cross-cutting topics and priorities in its Principles for Measure Selection to ensure that available measures in these areas were considered for inclusion in each of the core sets. Using a cross-cutting approach could result in misalignment among the CQMC core sets or conflict with the principles.

If CQMC were to use this approach, it could solicit potential topic areas from across membership, and the CQMC could prioritize based on the prioritization factors outlined in this document. CQMC members have expressed interest in core sets on disparities and patient experience.

Expanding the Current Core Sets to Address Additional Levels of Analysis and/or Settings

Some efforts have focused on identifying core measures that work across the care continuum and address multiple care settings. To date, the CQMC's current sets mainly focus on clinician measurement in the ambulatory care setting. Various workgroups, however, have already begun to include facility-level measures (mainly if clinician-level measures were not available), split sets between inpatient and ambulatory settings, or distinguish between measures based on whether they are intended for use in a specific delivery model (e.g., ACO versus PCMH).

Workgroups have expressed interest in expanding the CQMC's focus to other care settings or levels of analysis. For example, some workgroup members expressed interest in creating separate "sets," (e.g., ambulatory care and hospital-level, each under the "Cardiology" umbrella). Additionally, workgroup members noted that hospital-level measures are increasingly being attributed to physicians and used to assess their performance.

This approach has potential benefits of its own. First, it builds upon the current sets for a more comprehensive picture of quality for a particular condition and allows for measurement across the care continuum. This approach also supports holding a variety of providers responsible for the quality of an individual's care as one moves through the health system. Addressing additional levels of analysis, in particular, adding clinician-level analysis could help address some specific use cases. Patients may seek

information at the individual clinician level when choosing specific care such as surgery. Meaningful clinician-level information is rarely available to patients. Expanding the level of analysis on some measures could help close this gap. In a second use case, necessary care may be available in more than one setting (e.g. inpatient and a surgery center). The settings may have different cost implications for an accountable organization, insurer, employer, and/or patient. Without comparable quality information for the two settings, determining if the care is truly higher-value, as opposed to simply lower cost, is impossible. Having this information could contribute to performing well in APMs, value-based benefit design, and lowering patient out-of-pocket costs. Finally, this could allow the CQMC to build on its existing expertise. Current workgroups already include many of the necessary experts to expand work in the existing eight areas, while still allowing for involvement of new CQMC members.

This approach also has potential disadvantages. First, it could challenge the current parsimony and focus of the core sets. Numerous measures may need to be added to address a similar topic, as measures may not be specified to cross settings or levels of analysis. For example, a measure assessing hospital readmissions may need different specifications for use in assessing hospital performance versus clinician performance. Additionally, attribution challenges could further complicate measure selection, as there may be a lack of consensus as to who or which system should be accountable for an outcome. For example, health insurance provider members have expressed interest in seeing the CQMC support cost measures for the core sets, but many of the current episode-based cost measures attribute all costs for a given time period to the accountable entity of the measure. That is, a hospital may be attributed post-acute care costs, or a clinician may be attributed costs for a hospitalization. The accountable entities of the measures may disagree with the attribution, jeopardizing buy-in to the measures and sets that contain them. If clinicians should be held accountable for each of the core set measures has been a key discussion point by all workgroups. Clear guidance about how measures should be applied would be essential if core sets are expanded to additional levels of analysis.

Not every measure set will benefit from expansion across settings or level of analysis. For example, pressure injury measures could be important to include in a safety set for inpatient settings but less applicable to an outpatient setting. Similarly, vaccination measures could be appropriate for outpatient measurement but less meaningful for inpatient settings. Expansion to additional levels of analysis or care settings would benefit from consideration of the prioritization factors to avoid negatively affecting the overall efficiency and usefulness of the core sets. This approach may also delay the expansion of core sets to other clinical or cross-cutting topic areas or remove focus from promoting adoption of the current sets for programs or payment models that involve clinician measurement.

If the CQMC uses this approach, the current core sets could be expanded to include measures assessing hospitals or post-acute care providers.

Next Steps

A non-edited version of the draft report will be submitted to CMS for review. Following this review, NQF will incorporate feedback provided by CMS and post a copy-edited, 508-compliant version of the draft report for a public comment period.

Following the conclusion of the comment period, NQF will update the draft as needed to include the public comments. The final copy-edited and 508-compliant report will be submitted to CMS no later than 15 months after Task Order Award.

Appendix A

Efforts Focused on Stakeholder Priorities

National Academy of Medicine (NAM) Vital Signs[15]

The Vital Signs initiative focused on identifying measures for the health influences, characteristics, and interventions that would have the most influence on four domains: healthy people, quality of care, costs of care, and engagement in health and healthcare. The NAM committee considered the potential core measurement needs, priorities, and challenges for key stakeholder groups, including patients, families, and the public; clinicians; healthcare organizations; payers and employers; public health agencies at multiple levels; regulatory authorities; grant-making organizations; and media. One set of measures was chosen and intended to apply across all conditions.

NAM was specifically charged to identify measures that could improve population health outcomes and healthcare costs, and they prioritized measures that could achieve transformation across the system to promote these goals. Through its research, the committee identified four interrelated domains that could address these goals: healthy people, care quality, care costs, and engagement in health and healthcare. Measures were prioritized for the set if they advanced these specific goals. NAM's report on the development of the core set noted that the committee considered developing a set that included process measures but decided to focus on outcomes. Similarly, the report noted that NAM also considered focusing on individual disease areas but chose not to pursue that approach, as other measures could have a greater impact, address progress at multiple levels of the system, and maintain parsimony. This approach allowed NAM to develop a parsimonious and focused set. However, working backwards from specific goals meant that numerous areas did not have measures currently available. This approach could limit the CQMC's ability to promote alignment of measures currently in use.

New Jersey State Innovation Model[16]

In 2015, New Jersey was awarded a State Innovation Model (SIM) Design Grant from the Center for Medicare and Medicaid Innovation (CMMI). The SIM had as its goal to design a payment and service delivery model to reduce Medicare, Medicaid, and CHIP program expenditures while preserving or enhancing quality of care. The grant aimed to build on state initiatives already underway and the NJ SIM was designed to advance behavioral and physical health integration strategies; address Medicaid cost/value, especially for high-cost, complex patients; and improve birth outcomes through smoking cessation efforts, particularly among pregnant women.

Quality measure alignment was chosen as a core domain of the project activities. The work focused on aligning quality metrics across payers and the delivery system to improve quality and reduce redundancy and avoidable costs. The committee overseeing the alignment review prioritized the following considerations for measure review: (1) the relative importance for value-based system improvement; (2) the degree to which reporting requirements vary across payers; (3) metrics where reporting burden might outweigh their importance; and (4) where other opportunities to streamline measurement and reporting may exist. This initiative created a core set of measures through a multistep process. The first step was to identify the various state and federal quality and efficiency improvement initiatives and then create an inventory of metrics required under each initiative. The next step was to de-duplicate the list of metrics and identify those most commonly used. Measures on that list were then reviewed for meaningfulness and usability. Due to time constraints, this effort focused on outpatient measures rather than hospital inpatient measures.

This approach reviewed currently implemented measures for the outpatient setting to advance the

specific goals of the NJ SIM. This approach allowed for the creation of a parsimonious set of measures currently in use. However, this approach focuses on a specific time and may not allow for the addition or removal of core measures as needed. Similar to the CQMC, the initiative focused on outpatient measures, but using this approach may leave gaps in alignment for inpatient settings.

Rhode Island Aligned Measure Sets[17]

Rhode Island created a common set of quality measures to promote alignment across payers and reduce provider reporting burden. Rhode Island's State Innovation Model Grant supported the initial efforts. The goal of the aligned measure sets was to support a state goal of tying 80 percent of healthcare payments to value by addressing consistency of measures and provider burden. The vision for the core set was to create a menu of measures from which payers could select and a core set of measures to be included in all contracts. Areas for the core sets were selected based on payer interest. The first aligned measure sets focused on primary care, ACO, and hospital contracts. In 2016, additional measure sets were developed for behavioral health and maternity.

The process began with a review of existing measures used in value-based contracts between payers and providers in Rhode Island. A cross-walk was created between these measures and the measures in the CMS Medicare Shared Savings Program and Five-Star Quality Rating System, as well as the population health goals outlined in the SIM. Of note, the Workgroup charged with developing the sets was silent on whether measures shall be used for payment only, versus payment and/or reporting. Additionally, the workgroup noted that specific targets and incentives associated with the measures would be left up to negotiation between the health plans and providers. In 2017, the Office of the Health Insurance Commissioner's (OHIC) authority was updated to include requiring all commercial payers to use the measure sets in contracts with incentives tied to quality. This also transferred measure set development under OHIC.

The approach was designed to capitalize on payer interest and to meet the goals of the SIM. This process resulted in a clear vision for the sets and alignment of measures currently in use. Additionally, this approach allowed for prioritization of areas where there was misalignment in value-based purchasing (VBP) contracts and supported the state's desire to transition to greater use of VBP. This approach, however, may limit alignment of specialty-specific measures.

Washington State Common Measure Set for Health Care Quality and Cost[18]

Washington law mandated the creation of a statewide common measure set. The law created a Performance Measures Coordinating Committee charged with recommending standard statewide measures of health performance to inform public and private healthcare purchasers. Additionally, the Healthier Washington Initiative set a goal for 80 percent of all health plans and health care delivery systems in Washington State to use the Statewide Common Core Set of Measures by 2018. The core set was intended to evolve over time as measurement science advances, and a list of priority measure development areas was identified as part of its creation. This list focuses the research and recommendation of additional measures for the core set. Additionally, new topics for measure review and consideration can be identified based on state purchaser priorities.

The common measure set aims to promote voluntary measure alignment among state and private payers and to address specific state goals and needs. Measures in the set focus on access to primary care, acute care, prevention, and chronic care.

This approach focuses on addressing the priorities of public and private healthcare purchasers and aims

to ensure purchasers are invested in promoting adoption of the core set. This approach also resulted in the identification of gap areas where measures are not available. This approach, again, may limit the availability of specialty-specific measures.

Efforts Focused on Cross-Cutting Priorities

Measure Applications Partnership (MAP)[19]

MAP is a multistakeholder body convened by the National Quality Forum. MAP provides guidance on measures under consideration by the Centers for Medicare and Medicaid Services for use in its public reporting and VBP programs. To inform its measure selection work, MAP has developed sets of core measures. MAP's approach to prioritizing areas for the development of core sets was to focus the National Quality Strategy goals or on specific populations: dual eligible beneficiaries and rural health.

MAP adopted the approach of aligning with the aims of the National Quality Strategy or addressing the needs of specific populations to ensure measures are targeting important concept areas. This strategy aimed to promote broad improvement across the health system. MAP selected this approach to allow users of the core sets to achieve a twofold goal of tracking progress towards key improvement priorities and promoting alignment around best available measures. However, this approach could have key limitations. Measures may not work at multiple levels of analysis as currently specified, leading to the need for multiple measures addressing a similar topic. Moreover, this approach also led to the identification of numerous areas without available measures. This approach may allow the CQMC to include measures that span many conditions but, again, could be limited by the availability of appropriate measures.

Efforts Focused on Specific Purposes

Oregon Medicaid Metrics and Scoring Committee Criteria for Selecting Incentive Measures[20]

The Oregon Health Authority (OHA) measures quality of care and access to care for individuals enrolled in coordinated care organizations (CCOs) and the Oregon Health Plan population as a whole. A CCO is a network of healthcare providers in a community who serve people who receive healthcare coverage under the Oregon Health Plan (Medicaid).

The measure set has as its goal determining which CCOs are improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve. State law created the Metrics and Scoring Committee to recommend measures to assess CCOs. The set addresses specific domains of CCO quality including service areas for which CCOs are responsible and domains prioritized for transformation, specifically, care coordination, patient experience, access, equity, efficiency and cost control, and community orientation. Measures were drawn from existing sets and are reviewed periodically based on CCO performance data, improvement over baseline, and distribution of the quality pool to determine if the selected measures are improving quality and access for the Oregon Health Plan population.

This approach allows for the creation of a measure set to support a specific model and advance quality goals for the population included in that model. However, the core set may have limited applicability outside of that model and population, limiting the impact of alignment activities.

Maine State Innovation Model[21]

In 2013, Maine was awarded a three-year State Innovation Model (SIM) Grant from CMMI. Among other goals aimed at achieving the Triple Aim, the SIM aimed to improve health in at least four categories of disease prevalence, including diabetes, mental health, obesity, and tobacco use. As part of the SIM, the

Maine Health Management Coalition led a multistakeholder effort to develop a core measure set. A common set of core measures was created with the objectives of assessing ACO performance, aligning commercial and public payer performance measures, and reducing provider reporting burden. Performance on nine core measures broken out by MaineCare, Commercial, and Medicaid is displayed through a dashboard, allowing for the exploration of progress over time and in relation to 2016 targets.

The approach allows for the creation of a set to support specific goals and the use of a specific model. The potential drawback could be limited applicability in other models.

Massachusetts Executive Office of Health and Human Services (EOHHS) Quality Alignment Taskforce[22]

In 2017, the Massachusetts EOHHS convened a Quality Alignment Taskforce to create an aligned measure set for use by private and public payers and providers in global-budget. The measure set seeks to reduce burden and focus improvement efforts on state priorities. The taskforce was charged with recommending an aligned measure set for voluntary adoption by private and public payers and by providers in global budget-based risk contracts. The taskforce excluded ACO contracts for Medicare populations from its scope and did not consider measures for use in public reporting or in tiering of provider networks. The taskforce identified two goals for its work: (1) gain consensus on an aligned quality measure set for payers and providers to implement in global budget-based risk contracts and (2) to identify strategic priority areas for measure development where measure gaps exist.

The taskforce chose several ways to prioritize measures for the core set. First, it chose to include measures for both adult (nonelderly) and pediatric populations. Next, it identified 16 performance measure domains to represent important focus areas for the core set. Finally, the group chose to defer consideration and adoption of measures focused on inpatient care for future work. The taskforce used current measure sets as potential sources for its core set.

For 2020, the taskforce has selected a core set of measures to be implemented as a set and a "menu set" from which payers and providers may choose. The taskforce will be tracking implementation of measures in ACO contracts.

This approach allowed for the creation of a set that applies to a specific payment model and populations of interest. However, the focus on younger populations and measures for ACO models could limit the impact of alignment activities.

Vermont All-Payer Model ACO[23]

The goal of the Vermont All-Payer Model was to speed the transition from fee-for-service to risk-based payment models. The All-Payer Model enables the three main payers of healthcare in Vermont (Medicaid, Medicare, and commercial insurance) to pay an accountable care organization (ACO) differently than through fee-for-service reimbursement. This model is facilitated by state law and an agreement between the state and the Centers for Medicare and Medicaid Services (CMS). The model was facilitated through a partnership between the state's largest payers Medicare, Medicaid, and Blue Cross and Blue Shield of Vermont and with interest from a large established ACO.

To support this model, Vermont developed a set of core measures. To create this core set, Vermont prioritized three population health goals and built a quality framework around those goals: increase access to primary care; reduce deaths due to suicide and drug overdose; and reduce the prevalence and morbidity of certain chronic diseases. Overall, the quality framework consists of 22 measures across all payers and uses existing measures in order to minimize additional administrative burden.

This approach focused on developing a set to support payer and provider interest in payment reform and resulted in a parsimonious set advancing specific goals. However, this approach, built on Vermont's unique reform history, may not replicate nationally.

Efforts Focused on Specific Settings

Health Care Quality Measures-Minnesota Department of Health[24]

Minnesota's 2008 health reform initiative required the establishment of a standardized set of quality measures. This standardized quality measure set is called the Minnesota Statewide Quality Reporting and Measurement System. Physician clinics and hospitals have been reporting quality measures under the statewide system since 2010. Health plans may use the standardized measures and may not require providers to undertake reporting on measures outside of the system. Measures are categorized based on setting: physician clinic or hospital. The hospital set is further separated into measures for prospective payment system hospital, critical access hospital inpatient, critical access hospital outpatient, and prospective payment system and critical access hospitals.

Minnesota Department of Health is currently undergoing a significant effort to develop a measurement framework for the state and will position measurement and measurement sets within the context of the framework. The first legislative report on the framework is expected by the end of 2019, with implementation work beginning in 2020.

This approach covers a broad range of providers, and legislation limiting the use of measures outside this system supports measure alignment. This approach is built upon state reforms and local partnerships and replicating it elsewhere could prove challenging.

Efforts Focused on Specific Specialties

Kentucky Core Healthcare Measures Set (KCHMS)[25]

The Kentucky Performance Measures Alignment Committee (PMAC) developed the Kentucky Core Healthcare Measures Set. The PMAC is a public-private partnership between Kentucky Department for Medicaid Services (KDMS) and the Kentuckiana Health Collaborative (KHC). The Kentucky Core Measure Set focused specifically on primary care and pediatric care measures. The goals of the core set are to identify priority quality measures that improve the quality and value of care, reduce provider burden, and align Kentucky's healthcare organizations to focus on key indicators. The set includes 32 measures grouped in areas of prevention, pediatrics, chronic and acute care management, behavioral health, and cost/utilization.

Focusing on primary care allowed for the development of a parsimonious set that could advance specific goals. However, other specialties and settings may not benefit from the alignment effort and including these other providers could amplify improvement efforts.

New York State Innovation Model[26]

New York's State Innovation Model (SIM) focused on transforming primary care payment and delivery models. New York focused on using an advanced primary care model to achieve the goals of the SIM. Advanced primary care was defined as a patient-centered medical home model that provides patients with timely, well-organized, and integrated care.

A common measure set was created to support the implementation of the advanced primary care model. The core set of measures was designed to be shared across multiple payers and providers and to address quality issues across different regions of the state. The 2015 set includes 20 measures (all NQF-

endorsed) in the domains of prevention, chronic disease, behavioral health/substance use/patient-reported, appropriate use, and cost.

The approach resulted in a focused and parsimonious set that addressed key goals of the SIM; however, including other settings and specialties could have a farther-reaching impact on reducing provider burden.

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