

## State Innovation Model Initiative Quality Council

### Guiding Principles

In support of the task of establishing a multi-payer quality measurement set for use in the administration of Shared Savings Programs, the Quality Council shall seek to:

1. Maximize alignment with the Medicare Shared Savings Program ACO measure set.
2. Recommend additional measure elements of particular value to Medicaid and other payers including, but limited to, measures related to pediatrics, health equity, behavioral health, drawing from measures endorsed by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, CMS Meaningful Use Clinical Quality Measures, **NCQA measures, and the CMMI Core Measure Set**.
3. Recommend measures that are broadly applicable and optimally representative of the population of the State of Connecticut, which SIM reforms aim to impact. (Dr. Balla)
4. Recommend measures that will enable evaluation of the most prevalent health issues faced by the many subgroups within the State population. (Dr. Balla)
5. Recommend measures that promote maximal stakeholder and provider engagement in achieving high levels of performance. (Dr. Balla)
6. Establish meaningful and actionable measures from both the delivery system and patient standpoints, with an emphasis on patients/consumers. (Elizabeth Krause)
7. Maximize the establishment of a common core set of measures for all payers, recognizing the need for flexibility to add measures of particular relevance or interest to certain payers and their respective populations. (Elizabeth Krause)
8. Recommend that all measures be stratified by race, ethnicity, language, and other important demographic characteristics important to health equity. (Elizabeth Krause)
9. Plan for the future and not be constrained by data inadequacies that might be present today. This of course presents practical challenges. We should be realistic about what is currently collected and measured, but strive to make room for and spur transformation over four years. (Elizabeth Krause)
10. Maximize the use of outcome measures over process measures. (Elizabeth Krause)
11. Recommend measures for oral health, patient safety, consumer experience, chronic disease, and population health, keeping the number of measures practicable by focusing on effective proxies for overall performance. (Elizabeth Krause)
12. Measure quality at the level of the organization, not the clinician. (Berenson, et al)

**Comment [mcs1]:** Proposed by Dr. Balla

**Comment [mcs2]:** Proposed by Mark Schaefer

13. Measure patient reported experience with care and patient reported outcomes as ends in themselves. (Berenson, et al)
14. Use measurement to promote the concept of the rapidly learning health system. (Berenson, et al)
15. Maximize consumer access to provider quality measures. (Rexford)
16. Learn from and build upon existing systems and processes. (Wolfson)
17. Minimize both provider and payer implementation burden.

Comment: For example, adopting ACO measure #8 All-Cause Readmission Rate - while it has complete documentation on codes to select/exclude - the methodological section on the calculation algorithm of the measure is less defined and hard to follow (page 11). (Deborah Dauser Forrest)  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO-8.pdf>

For smaller health plans, resources may be limited to implement the full methodology of the measure without complete supportive documentation. The detail in this measure points to a citation (Horwitz et al, 2014) about the statistical methodology that is not readily available. To minimize implementation burden, the Quality Council will give careful consideration to the use of adopted measures. Mechanisms of operationalization might be through the suggestion to the Steering Committee that the grant provide for consultative services through the author (at Yale), Medicare statisticians who have computed each measure, comprehensive documentation of the measures steps - including all algorithms so that health plans can compute these measures with less burden, or the hired measurement consultant.

For consideration:

# of measures and relationship to provider focus, effective CQI

Are these for use in all performance based payment programs, or is our focus primarily on the larger SSP participating organizations

Should we think differently about advanced networks vs FQHCs