

# Steering Team Roster

## QUALITY FRAMEWORK

**Kelly Fluharty**, MPH, Community Care Organization Manager, Winona Health

**Monica Hurtado**, Racial Justice and Health Equity Organizer, Voices for Racial Justice

**Kevin Larsen**, MD, Enterprise Lean and Health IT Advisor, Centers for Medicare & Medicaid Services

**Deatrick LaPointe**, MA, Independent Consultant

**Jennifer Lundblad**, PhD, President and Chief Executive Officer, Stratis Health

**Ross Owen**, Health Strategy Director, Hennepin Health

**Diane Rydrych**, Director, Health Policy Division, MDH

**David Satin**, MD, Family Medicine Physician, University of Minnesota and University of Minnesota Physicians

**Julie Sonier**, President, MN Community Measurement

**Mark Sonneborn**, Vice President, Health Information and Analytics, Minnesota Hospital Association

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# Quality Framework Steering Team Meeting Summary

MAD Draft 3/12/18

## Present

Steering Team: Kelly Fluharty, Monica Hurtado, Kevin Larsen, Jennifer Lundblad, Ross Owen, Diane Rydrych, David Satin

MDH Staff: Stefan Gildemeister, David Hesse, Denise McCabe

MAD Consultants: Lisa Anderson, Stacy Sjogren

## Welcome and Introductions

Stacy Sjogren from Management Analysis and Development (MAD) welcomed everyone to the meeting. Stacy also reviewed room and conference call logistics.

The Steering Team Co-Chairs, Diane Rydrych from Minnesota Department of Health (MDH) and Jennifer Lundblad from Stratis Health, introduced themselves and led Steering Team introductions. Diane introduced the agenda.

## Background

Stefan Gildemeister (MDH) highlighted key local and national health policy initiatives to provide context for where we have been in Minnesota in terms of quality measurement and improvement, what has changed over time, and where we are now. Jennifer Lundblad noted three federal milestones:

- 2002 – Centers for Medicare & Medicaid Services (CMS) core measures reporting, now called Value-Based Purchasing for prospective payment system hospitals, and ever-increasing sophistication in hospital quality reporting;
- 2008 – Implementation of the Physician Quality Reporting System (PQRS) and other outpatient clinic and physician-focus efforts; and
- 2009 – Health Information Technology for Economic and Clinical Health (HITECH) Act.

Stefan teed-up discussion questions for the group to ponder and asked whether they were the correct questions to ask, such as:

- Should quality measures be linked to goals around quality improvement, population health, health equity goals, cost reduction, disease burden?

- Should all statewide measures be used in quality improvement, public reporting, and pay-for-performance, or are different measures better suited to different functions?
- How do we measure *other* settings or *across* settings along the care continuum?
- How do we align with other measurement strategies without being duplicative or redundant or going backwards, and maintain a system that is relevant for Minnesota?
- What do we all need to know to be part of health quality improvement and the delivery of high quality care?

## Discussion

- Q: What do we mean by “improvement?” A: MDH intentionally left that vague, so the Steering Team could help refine the meaning of “improvement.”
- In an environment of constrained resources, it will be important to make measurement and reporting more efficient and meaningful and to make sure to use all of the data that is collected. It is often difficult to know how hospitals and clinics use the data they collect.
- It is important to distinguish measurement and transparency as means to an end—what goal are we trying to achieve and for whom?
- It will also be important to think about how the data will be handled, especially for real time care delivery.
- Whatever the end result, MDH and the Steering Team must consider how it will impact the relationship between the patient and the provider and whether it increases trust between the community and the health care system.
- Health care quality improvement has lots of stakeholders, and MDH will have to be transparent about engaging them. It will be important to know the politics around this topic and who might be opposed to the end result.
- A potential outcome may be that SQRMS has run its course.

## Legislation

The Co-Chairs provided background on the legislative charge and reminded the Steering Team that the timeline is short but needs to create space for an iterative process. Legislation assumes that the Statewide Quality Reporting and Measurement System (SQRMS) will continue, but it could look very different.

## Discussion

One member suggested the group should discuss the impact of SQRMS to date. SQRMS was originally created to be a consistent set of measures. How successful was SQRMS in doing so? What should the goals be now? Is there a role for SQRMS in quality measurement and improvement?

# Steering Team Role

The Co-Chairs reviewed the Steering Team charter and the role of the Steering Team. The role of this group is to help shape the process for gathering stakeholder input, including how the project team asks about quality improvement and who the project team asks the question to; and synthesize the input provided by stakeholders.

Steering Team members discussed the Steering Team's role further. As MDH attempts to gather a wide variety of stakeholder input, the Steering Team's role will be to synthesize, digest, and mediate when hearing conflicting or opposing views. The Steering Team will not make recommendations but help the stakeholder voices that MDH is hearing from make sense and lead to a potential framework. The Steering Team will advise on process and on what information MDH asks from others.

The Steering Team also discussed the importance of language and using terms that hold the same meaning for everyone.

Other topics discussed include:

- The quality framework discussion with this Steering Team will not end with the report to the legislature; the effort to guide provider organizations to transparency and transformation is likely ongoing.
- There is currently no dominant model for what a framework should look like, though the Steering Team binders include examples of frameworks.
- It will also be important for the Steering Team to consider how stakeholders (providers, payers, patients) value quality measurement.
- Minnesota could use an incremental approach, where the report outlines a process for developing and testing the framework iteratively. We could start with a preliminary framework of two to three measures. We could demonstrate that we have tested the framework, not just thought about it.
- Other states have developed quality measurement systems for specific purposes. For example, measurement has been the solution for some states as they implement value-based purchasing initiatives and accountable communities for health. Other states want to drive down health care costs and use measurement in that way. Others encourage care coordination and the measurement infrastructure. Minnesota is a leader in health care quality measurement. What is the State's interest? What are the key drivers for the executive branch, and are there shared goals/value propositions across agencies? Minnesota can continue to take risks and trail blaze versus finding a national solution that makes sense for Minnesota in which Minnesota regresses to the mean.
- "Why not regress to the mean?" is the question before us. What can Minnesota do differently and better that is best suited to our market and populations?
- The Steering Team should strive to continue asking questions as the project evolves, rather than focusing on answering initial questions.
- Health disparities will continue to be an important topic.

- The conversation is very technical. Think about who will be affected by this framework and by MDH. How do we keep in mind that the experts know the jargon, and communities of color and indigenous communities are not on the same level—how do we deal with this tension?

## Stakeholder Engagement and Data Collection

Lisa Anderson from MAD presented the current data collection plan, a document that included research input from Steering Team members, and a starting list of stakeholders. MDH and MAD will reach out to additional stakeholders and seek for input from steering team members on other perspectives to include.

### Discussion

- Especially for clinics with few resources, observation may be an effective way to learn about the burden of measurement.
- MDH should include information from its 2014 Advancing Health Equity report.
- MDH and MAD should ensure that they also reach out to stakeholders that are not health care experts.
- It will also be important to know what thoughts the legislature has around this topic.
- There is a tension between wanting to be authentic in stakeholder engagement and the time available.
- In the interest of quality improvement, this will be an iterative process, meaning that questions may evolve. If questions evolve, the project team may need to circle back to people they already spoke with.
- The project team will vet questions with the Steering Team as time allows. This may mean work for the Steering Team between meetings.

### Next Steps

Stacy introduced next steps:

- Next meeting end of March/early April
- MAD will send Doodle polls for the remaining Steering Team meetings this week.
- Future communications to be found on MDH website, GovDelivery, or email [health.sqrms@state.mn.us](mailto:health.sqrms@state.mn.us).
- A meeting summary will be sent with the next meeting's materials.

### Public Comment

There was no public comment.

**Adjourn**

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# Summary of Steering Team Input on Current System

MAD Draft 3/26/2018

## Aspects of current measurement system that are valuable

### Most common responses:

- Minnesota has a multi-stakeholder system; many different stakeholders are involved.
- Minnesota is a leader.
- Standardized system helps community focus on quality improvement; having measures is important to improvement and the health of the population.

### Mentioned once:

- Minnesota has created a measurement culture.
- Minnesota focuses on outcome rather than process.
- Minnesota Community Measurement capacity is powerful because it drives down into populations in a way that hasn't been done before.
- Current measurement system includes an annual system for revisiting measurement points.
- The current measurement system is broad, truly a statewide approach that allows comparison among clinics.
- Current process for developing measures is good.
- Data that includes demographic and geographic information is helpful.
- Hospital measures are well-aligned with federal measures.

## Aspects that are challenging

### Most common responses:

- Reporting is burdensome - Some don't have adequate resources for all reporting – minimize administrative burden - align measures.

### Mentioned once:

- SQRMS is one of many (16) systems (MIPS, UCare Quality Measurement, to name a few).
- This generation's big challenge will be reconciling quantitative approach to quality improvement with providing clinical care.
- Tension between standardization nationally and local buy-in.
- Measurement system is regressive.

- Legislative input has limited SQRMS effectiveness because they haven't been interested in a multisector governance model.
- A lot of work goes into data collection and thinking about how data might be used and less about how we move collectively in response.
- Information is too technical for community use.
- Information is not easy to access.
- Implementation measures section has been a moving target.
- Assumes those who measure poorly can and will take steps to improve.

## Considerations

### Most common response:

- Need to consider relevance of measures to the consumer—use other consumer-based measures as examples. Start from consumer-focused perspective; focus on impact on patient care.

### Mentioned once:

- This is a great opportunity to build the best of all systems.
- Measurement has proliferated but not evolved.
- Possibility for system of exception reporting like UK.
- Would like to see risk adjustment.
- Don't lose what has already been accomplished through SQRMS.
- Consider the role of the state in fostering innovation.
- There needs to be a combination of stakeholder accountability and sustainability.
- MDH should not be the sole owner of SQRMS.
- Consider culture of providers and health systems in MN; of urban, suburban, and rural populations.
- Providers are willing to do more measures, not just claims-based measures.
- Consider the relevance to improvement performance of the health system; create information that can be acted upon.
- Don't sacrifice what is important to patients in order to align with the federal system of measures.
- Need to have the right decision makers and stakeholders at the table.
- It may be helpful to have separate but related conversations about: population health (reducing disparities), providing transparent information – common set of facts, and what innovation is necessary to fill in gaps.
- There needs to be more demographic information.
- Communicate information in a way that makes sense for consumers.
- Include perspectives beyond those of experts in the medical field.
- Measure quality of care, not just patient health.
- Minnesota still needs to have its own system, but in the long term they can completely align with other systems.



- Minnesota should innovate on performing based on measures that exist and devote resources to performance. The framework should be about improving patient care
- This is not just an MDH project; this is everyone's project.
- Need to define MDH's role in a statewide measurement system.
- Don't let the perfect be the enemy of the good.

## Questions/gaps in knowledge

**Most questions related to or directly asked about scope. All questions were asked once except the direct ask about scope, which was asked twice.**

- What is the scope of this framework development?
  - Specifically, how does MDH view the charge of the Steering Team?
  - Are we seeking alignment? Reducing the number of reports required?
  - What is the intended use of SQRMS? Single or multi-use? Multi-use is more robust but harder to figure out.
  - What is the governance of this going to look like? Public/private? Legislated?
  - What is the best scope of measurement?: Is it best aimed primarily at ambulatory or also extended to larger frame like hospital care, mental health care, etc.?
  - How will it be paid for?
  - Technical infrastructure: real time data? Claims and clinical? Where does the data sit and who has access? Patient level or aggregate?
- What types of changes would require legislative action? What types of changes does MDH have the authority to make?
- What stakeholders are driving the need for this framework? Who wins and who loses?
- Who is the roadmap for? Who is driving?
- What is the goal?
- Would like to know more about various federal programs and where they are headed, and how they might interact with Minnesota measurement systems.

## Success

**All successes were mentioned once, but many relate to one another.**

- The data shows patients live longer or live with less morbidity
- SQRMS is a model for other states and the federal government
- That whatever is developed is actionable and sustainable.
- Less burdensome (by 50%?) than current system
- Attempts made to create fairness of measurement funding
- System looks really different and is meaningful and value add
- Measures are the next iteration and not hospital or clinic specific but are patient-centered, meaningful, create accountability beyond hospital or clinic walls.
- We've preserved our focus on a robust outcome focused system that measures transparently.
- We don't recreate the wheel (not creating a new process that sits on top of existing process)

- That there are clear steps to follow to get to tangible change or improvement (spending less time doing collecting data).
- When it is actually implemented! Minnesota is great at coming up with frameworks and plans; not so great at following-through on commitment and action.
- People are paying attention to the product, and it's spurring conversation; people are engaged in the development of policy.
- Satisfied steering team members.
- MDH has used an authentic process, even if it means going past deadlines.
- Having some energy and excitement about a new effort to improvement in Minnesota.
- Agreement among and support from stakeholders.
- The framework is valuable in the community of stakeholders that will be using it.

# Stakeholder Conversation Outline

## Context

- In preparation of our conversations with stakeholders, we want to discuss what **topic areas** we should cover.
- We will develop a set of interview questions based on the Steering Team's input on the topic areas outlined below.
- Generally, we plan to follow a standard format for all stakeholder conversations, but we also hope to be able to follow-up on important threads in the conversation and supplement it with specific questions that align with stakeholders' experiences and areas of expertise.

## Conversation

- Introduction
  - Reflection on a recent personal experience with the health care system, including what worked well and what didn't, and what could have been better
- Discussion
  - If you were to imagine a different health care system/experience, what characteristics would it have? What would be important?
  - What does high quality health care mean for you? What role does health care play in maintaining health?
  - What would it take for us to consistently have high quality health care and know we do? Who would do what?
  - Do you think these values and principles for a quality framework can help create the health system evolution you imagine?  
*[Here, we would share the emerging values and principles from the Steering Team and ask for interviewees' reactions and additions.]*
  - How can we keep a quality framework and the system of measurement that flows from it relevant over time, how do we evolve?
- What have we not discussed that is important to consider when developing a quality framework and a roadmap towards it?

## Questions for the Steering Team

1. What topics, if any, are missing from the outline?
2. Given the variety of stakeholders we will have these conversations with and the gaps we just discussed, how can we ensure the conversation flows from talking about health and health care quality and includes measurement?

## Quality Framework Stakeholders

### Key informant interviews and small group discussions

*The project team will reach out to the stakeholders listed below to schedule key informant interviews and small group discussions. The project team will add others to this list during April through consideration and exploration of suggestions from the Steering Team, Internal Workgroup, and others.*

Consumer, community and advocacy organizations representing diverse communities and patients

- Health Equity Advisory and Leadership (HEAL) Council
- Quality Measurement Enhancement Project (QMEP) Community Engagement Team
- Somali, Latino and Hmong Partnership for Health and Wellness (SoLaHmo)
- Voices for Racial Justice and health equity champions

### Preliminary

- American Association of Retired Persons Minnesota
- American Cancer Society
- Eliminating Health Disparities Initiative grantees
- Minnesota American Lung Association
- Minnesota Board on Aging
- Minnesota State Councils
  - Council on Asian Pacific Minnesotans
  - Minnesota Council on Latino Affairs
  - Council for Minnesotans of African Heritage
  - Minnesota Indian Affairs Council
  - Minnesota State Council on Disability
- Patient Family Action Committees

Health care providers whose quality is assessed, and who serve primarily socioeconomically complex patient populations

- Minnesota Academy of Family Practice (MAFP)
- Minnesota Association of Community Health Centers (MNACHC) and some members
- Minnesota Association of Community Mental Health Programs (MNACMHP) and some members
- Minnesota Hospital Association (MHA)
- Minnesota Medical Association (MMA) physician workgroup for quality measurement project
- Safety Net Coalition (SNC)
- Small and large providers across Minnesota (clinics, hospitals)
  - University of Minnesota Physicians
  - Winona Health
  - Others

### Health care purchasers

- Hennepin Health
- Minnesota Department of Human Services (DHS)
- Minnesota Health Action Group (MNHAG)
- Minnesota Management and Budget State Employee Group Insurance Program (SEGIP)

### Health information technology

- Minnesota e-Health Advisory Committee

### Health plan companies

- Minnesota Council of Health Plans (MCHP) and some members

### Public health/Community health boards

- Some members of State Community Health Services Advisory Committee (SCHSAC)

### Quality improvement organizations

- Institute for Clinical Systems Improvement (ICSI)
- Stratis Health

### Quality measurement organizations

- MN Community Measurement

### Questions

1. Recognizing that we will use a multi-pronged approach to obtaining broad stakeholder feedback (e.g., interviews, surveys, public comment periods), what, if any, perspectives are missing from this list of stakeholders with which to hold in-person key informant interviews and small group discussions?
2. Some entities have offered to pull together small groups of stakeholders for these conversations (e.g., QMEP, MMA, and MHA). Are there other opportunities to create other small group discussions or listening sessions, particularly for consumers, patients, and community and advocacy organizations?



## PERFORMANCE MEASURES

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## QUALITY

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## CODING

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## REIMBURSEMENT

# CMS Framework for Measurement

CMS is the largest purchaser of health care in the world. In order to improve quality, safety and the delivery of high value health care for beneficiaries, CMS developed a framework for measurement that maps to the [six HHS National Quality Strategy priorities](#). Measures should be patient-centered and outcome-oriented whenever possible.

## Safety

- Hospital-acquired conditions (HACs)
- Health-care associated infections (HAIs)
- Unnecessary care
- Medication errors

## Person- and Caregiver-Centered Experience and Outcomes

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) or equivalent measures for each settings
- Functional outcomes
- Patient experience
- Caregiver experience
- Preference- and goal-oriented care
- Communication/shared decision-making

## Care Coordination

- Transition of care measures
- Admission and readmission measures

Patient and family activation

- Infrastructure and processes for care coordination
- Impact of care coordination

## Clinical Quality of Care

- HHS primary care and CV quality measures
- Prevention measures
- Setting-specific measures
- Specialty-specific measures

## Population/Community Health

- Measures that assess health of the community
- Measures that reduce health disparities
- Access to care and equitability measures

## Efficiency and Cost Reduction

- Spend per beneficiary measures
- Episode cost measures
- Quality to cost measures



# MEANINGFUL MEASURES

Initiative





# MEANINGFUL MEASURES | Initiative

Identifies high priority areas for quality measurement and improvement to improve outcomes for patients, their families, and providers.

## ● Promote Effective Communication & Coordination of Care

### Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

## ● Promote Effective Prevention & Treatment of Chronic Disease

### Meaningful Measure Areas:

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

## ● Work with Communities to Promote Best Practices of Healthy Living

### Meaningful Measure Areas:

- Equity of Care
- Community Engagement

## ● Make Care Affordable

### Meaningful Measure Areas:

- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

## ● Strengthen Person & Family Engagement as Partners in their Care

### Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Functional Status

## ● Make Care Safer by Reducing Harm Caused in the Delivery of Care

### Meaningful Measure Areas:

- Healthcare-Associated Infections
- Preventable Healthcare Harm

CMS.GOV

Scan QR code with your smart phone for information on **Meaningful Measures**.



# Assumptions (adapted from 03/12/18 presentation)

- **Commitment to measurement**
  - We assume commitment to measurement of health care quality in Minnesota, outside of federal requirements, will remain an important goal for stakeholders
- **Parsimony**
  - We believe in parsimony of measurement
  - *Being parsimonious with measures means using only as many measures as necessary to meet a program's goals – no more, no less. A negative view of parsimony is stinginess; a positive one is minimizing burden – National Quality Forum*
- **Different measures do different things**
  - We think it is rare that one measure can equally well serve multiple audiences – providers, payers and patients have different needs, interests and abilities
- **Build on success**
  - We want to build on our success but we are open for new ideas in:
    - What components of care to measure;
    - What data sources to use for measurement;
    - How to use data to understand health care quality and aims for improvement; and
    - How decisions about quality improvement and measurement priorities for Minnesota should be set, and the role of a range of stakeholders in shaping those priorities

# Minnesota Health Information Technology (HIT) Trailblazers Project

## Background

In September, 2012 the National Academy for State Health Policy (NASHP) and the Office of the National Coordinator for Health Information Technology (ONC) established the Health Information Technology (HIT) Trailblazer learning collaborative project. This project was designed to spark discussion among a small group of states on how to leverage investments in health information technology, data analytics, quality measurement/reporting, and quality improvement to achieve health care delivery system transformation goals.

NASHP and ONC selected four states to be a part of this learning collaborative: Minnesota, Oregon, Massachusetts, and Arkansas. An additional four states – California, Michigan, Maine and Rhode Island – will join the collaborative in November. These states were selected for their leadership in laying the groundwork for these efforts, particularly their readiness for moving toward a next-generation vision for quality measurement and improvement that harnesses the value of HIT.

At the state level, the core project team consists of representatives from the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) with expertise in HIT and electronic health record (EHR) adoption, data analytics, meaningful use, encounter data, quality

reporting, quality improvement, and payment reform activities at the state and national level.

## Project Activities

The HIT Trailblazer project is a 6-month, unfunded learning collaborative that is designed to help participating states plan and prepare to develop a long-term plan of action and next steps for quality improvement in the state. During the project period, states will participate in site visits, have opportunities to meet with national experts, and receive extensive technical assistance to help them develop a roadmap that identifies clear goals and milestones to be achieved in the short and long term. The initial project period is intended to support states in initiating focused discussions among stakeholders to gather input on the roadmap and the appropriate forum for on-going coordination and planning after the HIT Trailblazers project period ends.

## Draft Project Goals

As part of the initial planning, the Minnesota Trailblazer team has developed draft project goals to facilitate discussion on how Minnesota may want to bring together its strong work in HIT and quality measurement, reporting and improvement in order to best position itself for transformation.

***Goal 1: Develop a statewide vision for quality reporting and quality improvement that minimizes***

***provider burden and is aligned with statewide goals for improved population health.***

Through the HIT Trailblazers project, Minnesota will work with stakeholders to clearly articulate a statewide vision and framework for quality improvement, including roles/responsibilities of various organizations, balance between reporting and improvement initiatives, and clear standards for the establishment of new measures. The vision for quality measurement will include a model for maximizing use of HIT-enabled quality reporting, as well as linking and/or aligning provider-level and statewide quality measures wherever possible to create efficiencies and reduce provider burden.

***Goal 2: Achieve individual health, community health and practice improvement by effectively using data from EHRs /HIT and other sources for quality improvement, meaningful use, and to contribute to a learning health system.***

Minnesota communities are poised to advance the effective use of quality improvement information from EHRs to improve health at both the individual and community-level. Key readiness factors are Minnesota's strong rates of clinic and hospital EHR adoption and the high use of common functions such as e-prescribing, clinical decision support tools, and capacity to generate and transmit quality measures. This process will build on the work of the existing Minnesota e-Health Initiative, a public/private collaborative.

***Goal 3: Align data feedback for providers in total cost of care arrangements.***

Providers need actionable, timely data to improve quality and meet Triple Aim goals. Currently, providers receive data feeds from multiple payers that may differ in content and format, making it more challenging to compare results across payers or develop new approaches to care management or

care delivery. The State, in its role as a major payer/purchaser of health care (through Minnesota Health Care Programs and the State Employee Group Insurance Program), has the potential to convene and facilitate conversations with providers and payers about provider priorities and needs for actionable data and alignment of standards and formats for data feedback across payers; as well as potentially provide resources or assistance to providers in the area of data analytics.

### **Next Steps**

The topics included under this initial learning collaborative are of high interest to many organizations across Minnesota, and closely intertwined with numerous ongoing and potentially upcoming activities (including the State's proposed CMS State Innovation Model Testing grant). While this project is being convened and led by a team from MDH and DHS, the team envisions creating a forum for community discussion about how Minnesota can best harness our collaborative relationships, strong HIT/quality infrastructure, and statewide vision to move towards shared Triple Aim goals.

The core project team will be meeting with interested organizations during November, and planning for a stakeholder meeting before the end of the year to discuss how to move forward together on this work. The team will also be discussing other opportunities to share information about and receive input on this work.

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For more information, contact:

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## M E M O R A N D U M

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**TO:** Minnesota SIM Team  
**From:** Colin Planalp, SHADAC  
**Subject:** SIM states' quality measure alignment process and measure sets  
**Date:** Sept. 14, 2017

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This memo was written in response to a request for technical assistance from Minnesota for information on other states' efforts to develop common/aligned quality measure sets (TASC #00509704). This is a second memo for the TA request, following up on an interim product that focused on Massachusetts's quality measure alignment work, and incorporates feedback from Minnesota given during a call on Sept. 7. In addition to this memo, SHADAC has created an accompanying companion document that crosswalks measures used by the states identified in this memo (for those state that had publicly available relevant measure sets).

SHADAC will be available to discuss this memo on a dedicated call at Minnesota's convenience or respond to follow-up questions via email.

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### Massachusetts

In 2010, the Massachusetts legislature passed legislation requiring the state Department of Public Health establish a Standard Quality Advisory Council (SQAC) to create a Standard Quality Measure Set (SQMS) for "each health care provider facility, medical group, or provider group in the commonwealth."<sup>1</sup> The goal of this focus on quality measurement was to ensure that, as the state was pursuing efforts to contain health care costs, "savings not come at the expense of access to care and health care quality." The committee was established to advise the Massachusetts Center for Health Information and Analysis (CHIA), which maintains the measure set. SQAC convened in 2012 and has continued to meet in subsequent years for required annual revisions to the measure set. In earlier years of the committee, the group met more frequently (9 times in 2012), but meetings have become less frequent over time (2 times in 2016).<sup>2,3</sup> The council is composed of stakeholders prescribed by the legislation (as well as other non-voting members representing state agencies):

- Co-chairs:
  - Commissioner of health care finance and policy (or a designee)
  - Commissioner of the department of public health (or a designee)
- Up to 8 members, including:
  - Executive director of the group insurance commission (or a designee)
  - Medicaid director (or a designee)
  - And 6 representatives of organizations to be appointed by the governor, including at least:

- 1 representative from an acute care hospital or hospital association
- 1 representative from a provider group or medical association or provider association
- 1 representative from a medical group
- 1 representative from a private health plan or health plan association
- 1 representative from an employer association
- 1 representative from a health care consumer group

The legislation directed the committee to “(consult) with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures” and precluded the committee from “(selecting) quality measures that are still in development or (developing) its own quality measures.” It also required that the measure set must, at a minimum, include the following measure sets:

- Centers for Medicare & Medicaid Services (CMS) hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Healthcare Effectiveness Data and Information Set (HEDIS) reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group
- Massachusetts Ambulatory Care Experiences Survey

Over time, the process used by the committee to select measures has evolved, with changes to the group’s “selection criteria,” by which the committee determines whether measures should be recommended for the SQMS, as well as changes to the group’s “priority” areas, the domains in which the committee will consider new measures for potential adoption (see table below).

**Table 1: SQAC measure selection criteria and priority areas**

	2012 <sup>4</sup>	2013 <sup>5</sup>	2014 <sup>6</sup>	2015 <sup>7*</sup>
<b>Selection criteria</b>	<ul style="list-style-type: none"> <li>• Priority</li> <li>• Validity</li> <li>• Practicality</li> </ul>	<ul style="list-style-type: none"> <li>• Priority and alignment</li> <li>• Reliability and validity</li> <li>• Ease of measurement</li> <li>• Field implementation</li> <li>• Amenability to targeted improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Priority and alignment</li> <li>• Reliability and validity</li> <li>• Ease of measurement</li> <li>• Field implementation</li> <li>• Amenability to targeted improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Priority and alignment</li> <li>• Reliability and validity</li> <li>• Ease of measurement</li> <li>• Field implementation</li> <li>• Amenability to targeted improvement</li> </ul>
<b>Priority areas</b>	<ul style="list-style-type: none"> <li>• Efficiency and system performance</li> <li>• Care transitions and coordination</li> <li>• High-priority settings and clinical focus areas, specifically:</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health</li> <li>• Care coordination</li> <li>• Patient-centered care</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health</li> <li>• Care coordination</li> <li>• Patient centered care</li> <li>• Pediatrics</li> <li>• End of life care</li> <li>• Resource use/efficiency</li> </ul>	<ul style="list-style-type: none"> <li>• Appropriateness of Hospital-Based Care</li> <li>• End of Life Care</li> <li>• Integration of Behavioral Health and Primary Care</li> <li>• Maternity Care</li> <li>• Opioid Use</li> </ul>

	<ul style="list-style-type: none"> <li>○ Behavioral health</li> <li>○ Post-acute care settings</li> <li>○ Community and population health</li> </ul>			
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\* The SQAC’s 2016 selection were not specified in their report, but the priority areas did not change from 2015.<sup>8</sup>

Based on materials from SQAC meetings, it appears that staff from the state Center for Health Information and Analysis facilitated the committee’s work in earlier years. In 2014, the committee used the Lewin Group as a consultant to evaluate measures according to their selection criteria. Since 2015, the committee has been facilitated by a consultant (Bailit Health), which also conducted work to help the committee re-evaluate their quality measurement strategies and priorities, such as by conducting stakeholder interviews.<sup>9</sup> The committee also has hosted presentations by outside experts to inform the group’s decision-making process. We did not find information that Massachusetts has pursued other data collection efforts—such as measuring population health or health disparities—as part of their quality measure alignment work.

**Oregon**

In 2013, the Oregon legislature passed legislation establishing the Health Plan Quality Metrics Work Group to recommend an aligned set of quality metrics across state health programs, including Cover Oregon (the state health insurance marketplace), Oregon Health Authority (OHA) (i.e., Medicaid), and the Oregon Educators Benefit Board (OEBB) and Public Employees’ Benefit Board (PEBB).<sup>10</sup> While the authorizing legislation did not explicitly specify goals of the alignment effort, the work group itself identified a goal of aligning quality measures to achieve the Triple Aim of “better health care and better patient experience of care, better health, and lower costs.” The work group was composed of representatives of state agencies, other stakeholders and field experts, prescribed by the legislation:

- Representatives from agencies:
  - Cover Oregon
  - OHA
  - OEBB
  - PEBB
- Other stakeholders:
  - Insurer representative
  - Health care consumer representative
  - Self-insured (private) large employer representative
- Experts from the fields of:
  - Health care research
  - Health care quality measurement

The work group was given four main charges by the legislature in recommending an aligned measure set: 1) to “recommend measures that further the goals of the Oregon Integrated and Coordinated Health Care Delivery System” (i.e., the Medicaid Coordinated Care Organization program), 2) “recognize the unique needs and goals of OHA, Cover Oregon, OEBB, and PEBB,” 3) “consider quality measures and

measurement methodologies used by other state and national quality measurement efforts,” and 4) “use available quality measures and data systems to minimize redundant reporting and reporting with limited value.” We did not find detailed information on the process the Oregon work group followed to develop its recommendations (e.g., number and frequency of meetings, who facilitated discussions, etc.), but the group’s final report of recommendations did provide high-level information on the process, such as measure selection criteria and Triple Aim “drivers,” similar to Massachusetts’ “priority areas”:

Measure selection criteria

- Actionable and linked to outcomes of interest
- Reliable and valid, well-specified, and feasible to report
- Already within existing measure sets (specifically State Performance Measures or CCO Incentive Measures, Cover Oregon, OEBC or PEBB measure sets)
- Relevant for all lines of business (i.e., relevant to all four agencies)

Triple Aim “drivers”

- Addressing discrete health issues (e.g., diabetes, hypertension, asthma)
- Optimizing health care utilization, including:
  - Promoting use of appropriate procedures and medications
  - Reducing re-hospitalizations
  - Managing care delivered to “super utilizers”
  - Improving care at the end of life
- Integrating primary and behavioral health
- Ensuring appropriate care is delivered in appropriate settings
- Improving perinatal and maternity care
- Improving health and wellness for all populations, including:
  - Across the age span
  - Across demographic groups (equity)
  - Promoting wellness
- Providing patient-centered care

In addition to the work group’s measure selection criteria, it also considered whether measures were used in other and national quality measurement efforts.<sup>11</sup> As a result of its efforts, the work group recommended that Cover Oregon, OHA, OEBC and PEBB incorporate two sets of measures into their existing measurement sets: First, “Phase I” measures, that could be adopted immediately, and second, proposed “Phase II” measures that may not currently be possible for all plans immediately but that should be adopted once they could be “collected and reported more easily.” Based on available documentation, it is unclear the extent to which the recommendations were ultimately carried out; however, the state has since begun another effort at quality measure alignment.

In 2015, the Oregon legislature passed another law creating the Health Plan Quality Metrics Committee, which had a similar charge to the state’s earlier work group, to “(align) performance measures across state health care programs [to] ... encourage integrated and coordinated care, promote improved quality, health outcomes and patient satisfaction and help reduce costs.”<sup>12</sup> Like the earlier quality measure alignment effort, the law directed the committee to work with the OHA, PEBB, OEBC, and added the Department of Consumer and Business Services (DCBS) (not including Cover Oregon, as the earlier effort did).<sup>13</sup> The



legislature instructed that the committee should have members appointed by the governor from the following agencies and stakeholder groups:

- Representatives from agencies:
  - OHA
  - OEGB
  - PEBB
  - DCBS
- Other stakeholders:
  - Health care providers (2)
  - Representative of hospitals
  - Representative of insurers, large employers or multiple employer welfare arrangements
  - Representatives of health care consumers (2)
  - Representatives of CCOs (2)
- Experts from the fields of:
  - Health care research
  - Health care quality measurement
  - Mental health and addiction services

The legislation specified that OHA, OEGB, PEBB and DCBS were not required to adopt all of the measures recommended by the committee, but it prohibited them from adopting health outcome and quality measures not recommended by the committee. It also laid out instructions on how the committee should prioritize measures:

- A. Utilize existing state and national health outcome and quality measures, including measures adopted by the Centers for Medicare and Medicaid Services, that have been adopted or endorsed by other state or national organizations and have a relevant state or national benchmark;
- B. Given the context in which each measure is applied, are not prone to random variations based on the size of the denominator;
- C. Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden on the state, health benefit plans and health care providers;
- Enrolled Senate Bill 440 (SB 440-B) Page 3
- D. Can be meaningfully adopted for a minimum of three years;
- E. Use a common format in the collection of the data and facilitate the public reporting of the data; and
- F. Can be reported in a timely manner and without significant delay so that the most current and actionable data is available.

The committee began meeting in April 2017 and plans to meet monthly, and has hired a contractor (Bailit Health) to help facilitate the effort, along with OHA staff. This committee's work is currently underway and has not yet released a recommended measure set. The work of the earlier alignment effort was focused on aligning quality measures and did not address other measurement areas such as population health; based on available information, we did not find evidence that the current effort would expand to include a larger measurement effort.

## Maine

As part of its State Innovation Model award, Maine undertook a quality measure alignment effort to develop a common measure set to be used in Accountable Care Organization payment models. The Measure Alignment Work Group, created under the state’s SIM Accountable Care Implementation Committee, was given the following objectives:<sup>14</sup>

- a. Develop multi-payer measure set aligned closely with CMS ACO and MaineCare measures supplemented with metrics to address specific populations.
- b. To minimize the reporting burden, initial phase will rely on claims-based measures and available uniform survey results.
- c. Identify outcomes measures for adoption as reporting capabilities grow.
- d. Establish protocol for identification of “pending” measures (outcomes, functional status, etc).
- e. Recommend selected measures to Pathways to Excellence (PTE) for consideration for public reporting.

It was composed of members from health care providers/systems, payers, state and private employers, and representatives of Maine Quality Counts. The work groups’ efforts were facilitated by the Main Health Management Coalition and consultants from Bailit Health. The work group used the following selection criteria:

- Feasibility—reasonable cost without undue burden
- Scientific acceptability—reliable and valid
- “Setting Free”—useable across multiple settings and for different populations
- Usability/adaptability—understandable by intended audience
- Patient experience
- Existing state, regional, and/or national benchmarks
- Financial/incentivization—includes payment systems, P4P (hospital and physician based), rewards and penalties
- Improving this measure will translate into significant changes in value
- Durability—longevity of measure
- Multi-payer alignment—maximizes overlap of measures with CMS, MaineCare and commercial payers

While materials from some workgroup meetings are available online, it appears there may be a gap in the posting of meeting materials, so the number and schedule of meetings is unclear.<sup>15</sup> After the measure set was recommended by the relevant SIM committees, it was to be proposed to the Maine Health Management Coalition’s Pathways to Excellence program, which has an established process for selecting measures for public reporting. However, we did not find documentation on the outcome of that plan. This work was focused on developing a common set of measures for ACO payment and did not address other measurement areas (e.g., population health).

## Vermont

As part of its State Innovation Model award, Vermont undertook an effort to align quality measures in the state’s payment and delivery system transformation work (e.g., commercial and Medicaid ACOs) through its Quality and Performance Measures Work Group. Although this iteration of the state’s quality measure alignment work began in 2013, it was preceded by a similar ACO Measures Work Group.<sup>16,17</sup> The stated purpose of the SIM-based measure alignment workgroup was to “develop and recommend a standard set of performance measures, including metrics on quality, utilization, and cost” to allow the state to “evaluate Vermont’s payment reform models relative to public policy goals; to make recommendations regarding the manner in which quality performance will influence payments for payment models that are

tested; and to make recommendations about how and when to communicate quality performance relating to payment reform to consumers.”<sup>18</sup> Unlike other states’ efforts, Vermont did not make reduction of provider burden an explicit goal of its measure alignment efforts.

The work group’s charter described the following scope of work:

- Develop criteria and expectations for measure selection.
- Prioritize the use of nationally endorsed measures that can be benchmarked, to the extent possible.
- Develop consolidated and standardized sets of quality and performance measures for alternative payment and delivery system structures that are adopted for testing.
- Troubleshoot measurement collection and reporting barriers and support measurement issue resolution.
- Review performance measures on at least an annual basis and determine measures to be added, revised, retired, or replaced.
- Learn about, inform, and integrate relevant activities of other Vermont Health Care Innovation Project (VHCIP) work groups.
- Collaborate with other VHCIP work groups to achieve broader project goals.

The group met monthly, facilitated by staff from the state’s Green Mountain Care Board and the Department of Vermont Health Access, along with assistance from consultant Bailit Health. The workgroup members came from stakeholder groups including state agencies, payers (commercial health plans and Medicaid), health care providers and other groups (e.g., Vermont Legal Aid and Vermont Program for Quality in Health Care).<sup>19</sup> The established the following criteria for selecting quality measures:<sup>20</sup>

- Valid and reliable
- Representative of array of services provided and beneficiaries served by ACOs
- Uninfluenced by differences in patient case mix or appropriately adjusted for such differences
- Not prone to effects of random variation (measure type and denominator size)
- Consistent with state’s objectives and goals for improved health systems performance
- Not administratively burdensome
- Aligned with national and state measure sets and federal and state initiatives whenever possible
- Includes a mix of measure types
- Has a relevant benchmark whenever possible
- Focused on outcomes
- Focused on prevention, wellness and/or risk and protective factors
- Limited in number and including measures necessary to achieve state’s goals (e.g., opportunity for improvement)
- Population-based

The group also set specific criteria for measures to be used for payment:

- Presents an opportunity for improvement
- Representative of the array of services provided and beneficiaries served
- Relevant benchmark available
- Focused on outcomes
- Focused on prevention and wellness
- Focused on risk and protective factors
- Selected from the Commercial or Medicaid Core Measure Set

To evaluate the extent to which proposed measures met the workgroup’s selection criteria, it used a spreadsheet-style tool.<sup>21</sup> Based on workgroup meeting materials, it was not clear how proposed measures were identified, but an issue brief that summarized the effort reported that “workgroup invited stakeholders to propose measures...totaling more than 200 items.”<sup>22</sup> The workgroup made three measure set recommendations to the SIM steering committee: 1) measures to be used in ACO shared savings payment arrangements, 2) measures for reporting but not payment, and 3) “pending” measures for future consideration.<sup>23</sup> In collaboration with a population health workgroup, the Quality and Performance Measure Work Group also identified a state-level monitoring and evaluation measure set, which included measures of social determinants of health, such as unemployment rate and education.<sup>24</sup> Since the first recommendations, the work group continued its work to update the measures, but it is unclear whether those efforts have continued past 2015, when online documentation of workgroup meetings ended.<sup>25</sup>

### Connecticut

As part of its State Innovation Model, in 2014 Connecticut convened its Quality Council to “develop for recommendation ... a core set of measures for use in the assessment of primary care, specialty, and hospital provider performance,” as well as “a common provider scorecard format for use by all payers.”<sup>26</sup> The effort was aimed to “support continuous quality improvement by focusing health care providers on a single set of measures that are recognized by all payers” and “reduce provider and payer burden, cost, and inefficiency that is caused by measures that are too numerous or misaligned” by encouraging payers to voluntarily adopt a common set of quality measures as the state embarks on a multi-payer effort to transition to value-based payment models.<sup>27</sup> The council was created by the SIM Project Management Office, which facilitated the group’s work (with consultations from other organizations, such as the Centers for Medicare and Medicaid Innovation, and subject matter experts from Yale University), and included representatives from multiple stakeholder groups:

- Representatives from state agencies:
  - Department of Social Services
  - Department of Public Health
  - Office of the State Comptroller (i.e., state employee health plan)
  - Department of Mental Health and Addiction Services
- Consumer representatives:
  - Consumer Advocates
  - Community Organizations
  - Health Care Advocacy Organizations
  - Health Foundations

- Payer representatives:
  - Medicaid
  - Private Health Plans
- Health care provider representatives:
  - Physicians
  - Specialists
  - Nurses
  - Hospitals
  - American College of Physicians
  - Community Health Centers
  - Connecticut Hospital Association
  - Medical Groups

As part of its work, the council developed “guiding principles” for reference in considering measures for inclusion in the common measure set:

1. Maximize alignment with the Medicare Shared Savings Program Accountable Care Organization (ACO) measure set.
2. Recommend additional measure elements that address the most significant health needs of Connecticut residents, the needs of non-Medicare populations (e.g., pediatrics, reproductive health), and areas of special emphasis such as behavioral health, health equity, patient safety, and care experience.
3. Wherever possible, draw from established measures such as those already established by the National Quality Forum (NQF) and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, CMS Meaningful Use Clinical Quality Measures, National Committee on Quality Assurance (NCQA) measures, and the CMMI Core Measure Set.
4. Balance comprehensiveness and breadth with the need to prioritize and focus for the purpose of enabling effective and continuous quality improvement.
5. Promote measures and methods with the aim of maximizing impact, accuracy, validity, fairness and data integrity.
6. Promote credibility and transparency in order to maximize patient, employer, payer, and provider engagement.
7. Assess the impact of race, ethnicity, language, economic status, and other important demographic and cultural characteristics important to health equity. Leverage the output of this analysis to identify potential reportable metrics for inclusion in the scorecard.
8. Recommend measures that are accessible with minimal burden to the clinical mission; should draw upon established data acquisition and analysis systems; should be both efficient and practicable with respect to what is required of payers, providers, and consumers; and should make use of improvements in data access and quality as technology evolves and become more refined and varied over time.
9. Maximize the use of clinical outcome measures and patient reported outcomes, over process measures, and measure quality at the level of the organization.
10. Use measurement to promote the concept of the Rapidly Learning Health System.

Although the council focused its work on measures for non-Medicare populations, they began their work by compiling measures used in the Medicare Shared Savings Program “because it is the nation’s largest

value-based payment program and uses a single nationwide set of quality measures.” The council’s report also noted that they aligned with the program because “there is little or no opportunity to alter the quality measures that Medicare uses, (so) aligning with the Medicare SSP also reduces the burden on providers who intend to participate in commercial or Medicaid value-based payment arrangements in Connecticut.” The council also compiled for consideration measures used by the state’s five largest commercial payers’ value-based payment programs and measures used by the state Department of Social Services’ Patient Centered Medical Home program, which includes Medicaid and CHIP enrollees. Because the council determined that some priority areas (e.g., behavioral health) were not well-represented in those measure sets, they also considered measures from other existing national measure sets (e.g., the Physician Quality Reporting System), measures stewards (e.g., the National Committee for Quality Assurance), and measure sets from certain other states.

To pare the measure list it had compiled, the council implemented a multi-level review process, in which it considered questions such as whether a measure addressed priority areas (e.g., addressing concerns of health disparities), overlapped with other measures or had little room for improvement; and it applied the Robert Wood Johnson Foundation’s Buying Value Measure Selection Tool to assess whether measures were already aligned across multiple payers and met the council’s selection criteria.<sup>28</sup>

- Base rate sufficiency
- NQF endorsement
- Availability of an appropriate benchmark
- Opportunity for improvement
- Outcome vs process measure
- Health equity value

**Table 2: Connecticut SIM Quality Council multi-level review process**

	Level 1	Level 2	Level 3
<b>Considerations</b>	<ul style="list-style-type: none"> <li>• Is the measure part of the Medicare ACO SSP set?</li> <li>• Does the measure address a significant population health concern based on prevalence?</li> <li>• Does the measure address a health disparity concern?</li> <li>• Is there another compelling reason that the measure should be used for SSP, e.g., the measure represents a known patient safety, quality, or resource efficiency/cost concern?</li> </ul>	<ul style="list-style-type: none"> <li>• Is the measure appropriate for VBP for ACOs (e.g., eliminate measures recommended for individual clinicians, home health agencies, hospitals, etc.)?</li> <li>• Is the measure easily tied to QI efforts at the level of the ACO?</li> <li>• If the measures within a performance domain or sub-domain (e.g., diabetes care) are in excess of what is necessary to demonstrate improved performance, retain those measures which</li> </ul>	<ul style="list-style-type: none"> <li>• Culling                             <ul style="list-style-type: none"> <li>○ Is the measure a process measure for which an available outcome measure would better serve?</li> <li>○ Is there an opportunity for improvement or does the measure represent an area where the state is already performing well (consider for significant sub-populations if known)</li> <li>○ Is there likely to be sufficient variation among provider organizations?</li> <li>○ Does measure meet feasibility,</li> </ul> </li> </ul>

		<p>serve as the best indicators of improvement.</p> <ul style="list-style-type: none"> <li>• De-duplication             <ul style="list-style-type: none"> <li>○ Is the measure the same or similar to another measure (e.g., “hospital admissions for asthma among older adults” is subsumed within “hospital admissions for COPD or asthma among older adults”)</li> </ul> </li> </ul>	<p>usability, accuracy and reliability standards?</p> <ul style="list-style-type: none"> <li>• Check for conflicts with guiding principles</li> <li>• Reconsider previously rejected measures if necessary</li> </ul>
<b>Actions</b>	Provisionally accept if one, two, or three of the above is true.	Provisionally accept if one of the above is true.	Accept those that remain.

Of note regarding Connecticut’s measure selection criteria is the inclusion of “health equity value,” which was unique among the states we examined. This was included because the issue of health equity and disparities is a key focus area for the state’s SIM, and that criteria is designed to leverage the state’s quality measure alignment effort to fit with the state’s other SIM efforts to better measure and address disparities. For example, through its SIM, Connecticut has expanded its Behavioral Risk Factor Surveillance System (BRFSS), in part to improve measures of disparities.

The state’s Quality Council met approximately twice per month from Sept. 2014 to Dec. 2015, when a draft of its measure set recommendations was prepared.<sup>29</sup> Since then, the council has continued to meet but on a less-frequent basis of every one-to-two months. In October 2016, the committee released its final recommendations for primary care measures for public comment. The recommendations were separated into three components: 1) a Core Measure Set for value-based payment arrangements, 2) a Development Measure Set for future consideration for payment, but which require additional development or modification, and 3) a Reporting Measure Set to be monitored but not used for payment.

**Rhode Island**

As part of its State Innovation Model, in 2015 Rhode Island convened a Measure Alignment Workgroup “to develop an aligned measure set for use across all payers in the state.”<sup>30</sup> The goal of the workgroup was to propose a “menu” of measures that payers could select from, as well as “specific core sets of measures to be included in all contracts.” The workgroup was facilitated by consultants from Bailit Health and included representatives from the following stakeholder groups:

- Payers
- Providers
- Measurement experts
- Consumer advocates
- Other community partners

In its first year, the workgroup held 12 meetings over nine months, reviewing sets of measures that were being used in value-based contracts by payers in the state and cross-walking them against CMS Medicare Shared Savings Program and 5-Star measure sets. Using the Buying Value Tool, the workgroup also evaluated the measures for alignment and whether the measures met the selection criteria that the group established:

- Evidence-based and scientifically acceptable
- Has a relevant benchmark (use regional/community benchmark, as appropriate)
- Not greatly influenced by patient case mix
- Consistent with the goals of the program
- Useable and relevant
- Feasible to collect
- Aligned with other measure sets
- Promotes increased value
- Presents an opportunity for quality improvement
- Transformative potential
- Sufficient denominator size

In 2016, the RI SIM Steering Committee endorsed the Measure Alignment Workgroup’s recommended measure set, which included “core measures” specifically for ACOs, primary care providers and hospitals, which commercial insurers are required by the RI Office of the Health Insurance Commissioner to include in all performance-based contracts beginning in January 2017. The measure set also included optional “menu” measures that payers and providers could select from. Although the state did not include any measures of social determinants or population health in its measure sets, Rhode Island did evaluate the considered measures against the state’s SIM population health priorities: diabetes, tobacco use, obesity and hypertension. The state also incorporated the measure set into its Medicaid Performance Goal Program and anticipates aligning its Medicaid Accountable Entity program with the measure set.

Since the state adopted the aligned measure set, the workgroup has followed up its work with annual review process to revise the measure set based on “change in NQF or NCQA status, new HEDIS measures, and measures recommended by the specialist workgroups.” As part of the state’s measure set revision process, it also convened two Specialist Measure Alignment Workgroups in 2016 to recommend measures for maternity and behavioral health care. The specialist workgroups operated like to the main workgroup, including a similar group of stakeholders (payers, provider groups, professional associations, state agency/public payer representatives and advocates), using the same measure selection criteria, and recommending “core” measures to be required and a menu of optional measures.

## Washington

In 2014, the Washington legislature passed legislation establishing a performance measures committee to “identify and recommend standard statewide measures of health performance to inform public and private health care purchasers ... to track costs and improvements in health outcomes.”<sup>31</sup> The legislation prescribed that the committee should include representatives of particular stakeholder groups:

- State agencies
- Small and large employers
- Health plans
- Patient groups
- Federally recognized tribes



- Consumers
- Academic experts on health care measurement
- Hospitals
- Physicians
- Other providers

The legislation required that the measure set include areas of:

- Prevention and screening
- Effective management of chronic conditions
- Key health outcomes
- Care coordination and patient safety
- Use of the lowest cost, highest quality care for preventive care and acute and chronic conditions

The legislation also instructed that the measure set:

- (Be) of manageable size
- (Be) based on readily available claims and clinical data
- (Give) preference to nationally reported measures and, where nationally reported measures may not be appropriate, measures used by state agencies that purchase health care or commercial health plans
- (Focus) on the overall performance of the system, including outcomes and total cost
- (Be) aligned with the governor's performance management system measures and common measure requirements specific to Medicaid delivery systems under RCW 70.320.020 and 43.20A.895
- (Consider) the needs of different stakeholders and the populations served
- (Be) usable by multiple payers, providers, hospitals, purchasers, public health, and communities as part of health improvement, care improvement, provider payment systems, benefit design, and administrative simplification for providers and hospitals

While we were unable to find detailed information on the process followed by the committee in its first year, publicly available documentation shows that after recommending an initial Common Measure Set, the committee has continued its work in subsequent years, reviewing and revising the measure set, and convening workgroups to recommend additional measures in priority areas such as behavioral health and pediatrics.<sup>32,33,34</sup> Materials on the committee's later work include their measure selection criteria:<sup>35</sup>

- Measures are based on readily available data in WA (data source must be identified before measure approved).
- Preference given to nationally-vetted measures (e.g., NQF-endorsed) and other measures currently used by public agencies within WA
- Each measure should be valid and reliable, and produce sufficient numerator and denominator size to support credible public reporting.
- Measures target issues where we believe there is significant potential to improve performance in a way that will positively impact health and reduce costs.

- When possible, align with the Governor’s performance management system measures and measures specific to Medicaid.
- If the unit of analysis includes health care providers (i.e., medical groups, hospitals), the measure should be amenable to the influence of providers.
- The measure set is relevant to multiple parties (e.g., payers, provider organizations, public health, communities, and/or policy-makers).

Under SIM, Washington set a goal for “80 percent of all health plans, health care and delivery systems in the State of Washington to be using the Statewide Common Core Set of Measures to measure and improve health care quality and cost performance by 2018.”<sup>36</sup> According to the state’s 2015 SIM operational plan, “commercial payers have voluntarily committed to participating in public reporting of the common measure set ... (and) the state is investing in a campaign that targets purchasers to promote the adoption of the measure set.”<sup>37</sup> According to materials from the Washington Health Care Authority, performance on the Common Measure Set will be published by the Washington Health Alliance, a non-profit organization that publishes other data on health in the state, such as reports on health disparities.<sup>38,39</sup>

### **Michigan**

As part of its SIM, Michigan is undertaking a plan to align “all participating payors and providers” using a common measure set based on a separate effort led by the Michigan State Medical Society and Michigan Health Information Network Shared Services —the Physician-Payer Quality Collaborative.<sup>40</sup> The collaborative, which includes provider organizations, Medicaid and commercial payers,<sup>41</sup> aims to “reduc(e) the administrative and reporting burden to providers in the state.” We were able to find the collaborative’s recommended measure set, but based on publicly available documentation we were unable to find details on the process used to develop the recommendations.<sup>42,43</sup>

### **Wisconsin**

Since 2011, the Wisconsin Statewide Value Committee has led an effort to align measures.<sup>44</sup> The efforts’ goals are to: “(1) developing clear expectations for value; (2) establishing an agreed-upon set of measures of value across all stakeholders; (3) rewarding providers to improve health, not manage sickness; and (4) publicly reporting measures.”<sup>45</sup> The committee includes representatives from three stakeholder groups: 1) payers (e.g., Medicaid, other state purchasers, health plans, private employers), 2) health care providers, and 3) consumers, as well as other groups, such as the Wisconsin Collaborative for Healthcare Quality. A 2014 issue brief noted that the group followed a measure selection process to recommend a common measure set, but we were not able to determine with available documentation whether and how a measure set was adopted and maintained.<sup>46</sup>

### **Iowa**

Although we did not find evidence of a common/aligned quality measure set or process to develop one in Iowa, SIM materials do describe how Iowa has adopted quality measures used by a commercial payer in the state (Wellmark) in the state’s Medicaid’s MCO and ACO program.<sup>47,48</sup>

### **Colorado**

We did not find evidence of a common/aligned quality measure set or process to develop one in Colorado, but SIM materials do describe how Colorado’s SIM and Medicaid measures align in many cases with federal programs, such as the Comprehensive Primary Care Initiative and Transforming Clinical Practice Initiative.<sup>49</sup>

## Arkansas

Although Arkansas's SIM included components that involved multiple payers using the same quality measures (e.g., episodes of care), we did not find documentation of a process to develop an aligned/common measure set in the state.<sup>50</sup>

## Utah

Through Utah's SIM design award, the state proposed creation of a workgroup to develop a common measure set for the state; however, we did not find information that such an effort has yet been undertaken.

<sup>1</sup> Massachusetts Statewide Quality Advisory Committee. "Year 1 Final Report: January-November 2012". Available at: <http://www.chiamass.gov/assets/docs/g/sqac/sqac-final-report-11-9-12.pdf>

<sup>2</sup> Massachusetts Center for Health Information and Analysis (CHIA). "Statewide Quality Advisory Committee (SQAC) Archive." Available at: <http://www.chiamass.gov/statewide-quality-advisory-committee-sqac-archive/>

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