Connecticut Quality Council
Potential Criteria to Inform Measure Selection

Quality Council Core Measure Set Introduction

The overarching aim of the Quality Council Core Measure Set is to promote alignment of quality measures in use by commercial insurers and Medicaid to assess and reward the quality of services delivered under value-based payment arrangements with Advanced Networks.[1] These criteria are being developed to guide the work of the Quality Council members in recommending measures to the Office of Health Strategy for measure set inclusion.

Quality Council members must exercise judgement in determining whether criteria are met for individual measures and for the measure set as a whole. Measures do not need to satisfy all of the individual measure criteria in order to be selected.

Quality Council Subcommittee Task

For each set of criteria, the Subcommittee should ask two primary questions:

1. Which criteria does the Subcommittee recommend bringing back to the Quality Council on January 21st for use with the Core Measure Set?
2. What specific language (after considering CT, MA and RI) does the Subcommittee recommend?

The Subcommittee's recommendations will be presented to the Quality Council for final approval and use with the Core Measure Set on January 21st.

Quality Council Survey Results

The Quality Council responded to a survey during the December 17th meeting to indicate which criteria members recommended applying to individual measures and the measure set as a whole. Quality Council members were directed to select up to five criteria for each. 18 members responded to the survey. Survey results are provided in the relevant sections below.

[1] OHS' working definition of "Advanced Network" is a provider organization or contractually affiliated group of provider organizations that either (a) holds a value-based contract with a payer or (b) is able to hold a value-based contract by virtue of having a sufficient number of primary care providers.

Criteria to Apply to Individual Measures

As a reminder, these criteria are meant to ensure that each measure has sufficient merit for inclusion in the Core Measure Set. The following graph displays the Quality Council's recommendations on criteria to apply to individual measures.

The criteria in the table below are ranked according to the Quality Council's survey results. The table includes the language that Connecticut's Quality Council previously utilized as well as language that is currently in use in Massachusetts and/or Rhode Island.

	Criterion	CT Criterion	MA Criterion	RI Criterion
1	**Promotes health equity**	Assess the impact of race, ethnicity, language, economic status, and other important demographic and cultural characteristics important to health equity.	Represents an opportunity to promote health equity. • When reviewing individual measures, the Taskforce will examine performance stratified by race, ethnicity, language and disability status as well as the decomposition of inequities between and within providers, where data are available • Taskforce staff will request stratified data from state agencies and Taskforce members and look for stratified data from other states and the research literature.	
2	**Opportunity for improvement**	Prioritize outcome-focused measures with opportunity for improvement, variability among provider organizations and available appropriate benchmarks, where available.	Represents an opportunity to improve population health.	Present an opportunity for quality improvement.

	Criterion	CT Criterion	MA Criterion	RI Criterion
3	**Feasible to collect/ not burdensome**	Recommend measures that are accessible with minimal burden to the clinical mission, and that • draw upon established data acquisition and analysis systems; • are both efficient and practicable with respect to what is required of payers, providers, and consumers, and • make use of improvements in data access and quality as technology evolves and become more refined and varied over time.	Generated without causing extensive burden, or the measure would reduce burden by supplanting an existing measure in the Aligned Measure Set with greater burden, or the associated burden is justified by reasonably expected high impact on patient health resulting from the measure's use.	Feasible to collect.
4	**Evidenced-based**		Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health.	Evidence-based and scientifically acceptable.
5	**Addresses state health priorities / needs and/or measure set goals**	Address the most significant health needs of Connecticut residents, with attention to areas of special priority, including: • behavioral health • health equity • patient safety, and • care experience.	Addresses a State-defined health care priority or fills a gap in the Aligned Measure Set of Taskforce priority.	Consistent with the goals of the program.

	Criterion	CT Criterion	MA Criterion	RI Criterion
6	**Valid and reliable**	Promote measures and methods with the aim of maximizing impact, accuracy, validity, fairness and data integrity.	• Valid at the data element and performance score level.[2] Any exclusion criteria are also valid. • Reliable at the data element and performance score level across providers.[3]	
7	**Can be operationalized**			• Useable and relevant • Sufficient denominator size
8	**Promotes value**			Promotes increased value.
9	**Promotes credibility and transparency**	Promote credibility and transparency in order to maximize patient, employer, payer, and provider engagement.		
10	**Appropriate for ACOs**	Ensure measure is appropriate for use in an ACO contract.	Appropriate for use in an ACO contract. For this purpose, an ACO is defined as a provider organization that has entered into a global budget-based risk contract with a commercial or MassHealth (Medicaid) payer.	
11	**Broadly applicable**			Not greatly influenced by patient case mix.

[2] For this purpose, the NQF definition of validity is used: "Validity refers to the correctness of measurement. Validity of data elements refers to the correctness of the data elements as compared to an authoritative source. Validity of the measure score refers to the correctness of conclusions about quality that can be made based on the measure scores (i.e., a higher score on a quality measure reflects higher quality)." www.qualityforum.org/Measuring_Performance/Scientific_Methods_Panel/Meetings/2018_Scientific_Methods_Panel_Meetings.aspx. Taskforce staff will update this language, as necessary, to reflect any modifications to NQF's definition of validity.

[3] For this purpose, the NQF definition of reliability of the measure score is used: "Reliability of the measure score refers to the proportion of variation in the performance scores due to systematic differences across the measured entities (or signal) in relation to random error (or noise)." www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=87595. Taskforce staff will update this language, as necessary, to reflect any modifications to NQF's definition of reliability of the measure score.

	Criterion	CT Criterion	MA Criterion	RI Criterion
12	**Prioritizes nationally-endorsed measures**		No nationally endorsed measures (i.e., endorsed by NQF, NCQA, or CMS, or other national recognition bodies[4]) are available for use, or the Taskforce has evaluated the nationally endorsed measures as failing to meet other Taskforce measure selection criteria.	Utilizes a HEDIS measure when multiple options exist.
13	**Has a relevant benchmark**	Prioritize outcome-focused measures with opportunity for improvement, variability among provider organizations and available appropriate benchmarks, where available.		Has a relevant benchmark (use regional/community benchmark, as appropriate).
14	**Can be transformative**			Transformative potential.

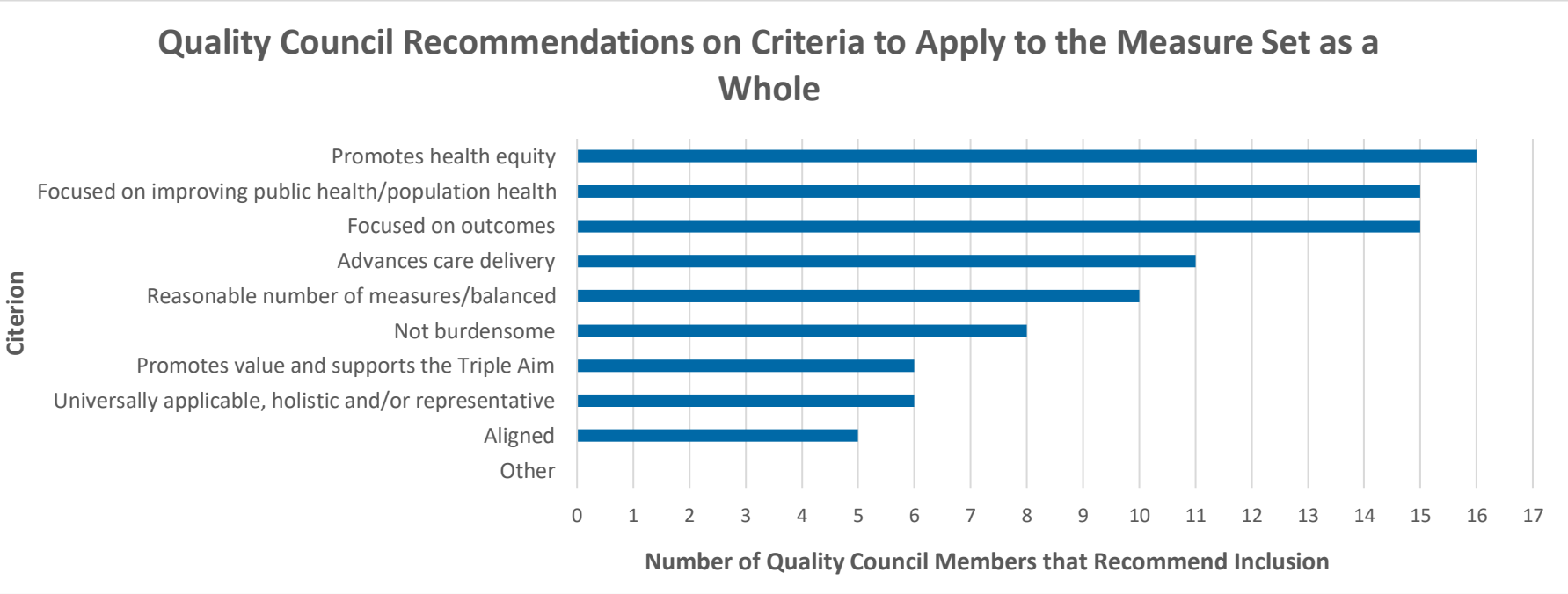
[4] A national recognition body is a widely recognized national organization that has a structured process for the review and endorsement of health care quality performance measures for use in quality improvement, public reporting and/or value-based payment. Examples include the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), and the Centers for Medicare and Medicaid Services (CMS).

	Criterion	CT Criterion	MA Criterion	RI Criterion

15	**Aligned with select measure sets**	• Maximize alignment with the Medicare Shared Savings Program and NextGen ACO measure set.
		• Wherever possible, draw from national measure sets such as:
		  ○ National Quality Forum (NQF) measures;
		  ○ CMS Adult and Child Health Care Quality Measures for Medicaid;
		  ○ CMS Merit-based Incentive Payment System (MIPS);
		  ○ CMS Electronic Clinical Quality Measures (eCQMs);
		  ○ National Committee on Quality Assurance (NCQA) measures, &
		  ○ Core Quality Measures Collaborative core measure sets.
				Aligned with other measure sets.

Criteria to Apply to the Measure Set as a Whole

As a reminder, these criteria are meant to more holistically assess whether the Core Measure Set is representative and balanced, and meets the policy objectives identified by the Quality Council. The following graph displays the Quality Council's recommendations on criteria to apply to individual measures.



The criteria in the table below are ranked according to the Quality Council's survey results. The table includes the language that Connecticut's Quality Council previously utilized as well as language that is currently in use in Massachusetts and/or Rhode Island.

	Goal	CT Criterion	MA Measure Set Criterion	RI Measure Set Criterion
1	**Promotes health equity**		Includes topics and measures for which there are opportunities to promote health equity by race, ethnicity, language and/or disability status.	
2	**Focused on improving public health / population health**			Broadly address population health.
3	**Focused on outcomes**	• Prioritize outcome-focused measures with opportunity for improvement, variability among provider organizations and available appropriate benchmarks, where available. • Maximize the use of clinical outcome measures and patient-reported outcomes, over process measures, and measure quality at the level of the organization.	Prioritizes health outcomes, including measures sourced from clinical and patient-reported data.	
4	**Advances care delivery**		Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.	

	Goal	CT Criterion	MA Measure Set Criterion	RI Measure Set Criterion
5	**Reasonable number of measures/balanced**	Balance comprehensiveness and breadth with the need to prioritize and focus for the purpose of enabling effective and continuous quality improvement.	Strives for parsimony.	
6	**Not burdensome**			Not unreasonably burdensome to payers or providers.
7	**Promotes value and supports the Triple Aim**		Promotes value for patients, purchasers, and providers and supports the triple aim of better care, better health, and lower cost.	
8	**Universally applicable, holistic and/or representative**		Provides a largely complete and holistic view of the entity being evaluated (i.e., an ACO).	• Representative of the array of services provided by the program. • Representative of the diversity of patients served by the program.
9	**Aligned**		Comprised of measures that are highly aligned across existing payer ACO contract measures.	