

**Accountable Care Implementation (ACI) Steering Committee**

**Meeting Notes**

**January 14, 2014**

**Gov. Hill Mansion, Augusta**

**Attendance:** Judi Hawkes, Mercy; Mike Hachey, Mercy; Pamela Beaule, St. Mary’s; Frank Bragg, MD, EMMC/EMHS; Carrie Arsenault, EMHS/Beacon; Patrick Denning, Harvard Pilgrim Health Care; Ned Claxton, MD, Central Maine Health; John Yindra, MD, Maine Community Health Option; Jim Kane, CMMC; Tom Hopkins, University of Maine System; Andy Ellis, Anthem BCBS; Cheryl Rust, Le Garage; Carl DeMars, Mid Coast Health; Katie Fullam Harris, MaineHealth; Barbara Crowley, MD, MaineGeneral Health; Barbara Leonard, MeHAF; Michelle Probert, MaineCare; David Winslow, Maine Hospital Association; Dan Dyer, Aetna (remote); Mark Still, Cigna (remote); Loni Levesque, University of Maine System (remote); Bruce Wagner, Mercy (remote); Robert McCue, Mid Coast Health (remote); Judiann Smith , Spurwink (remote); Any Cotton, EMHS (remote); Katherine Pelletreau, Maine Association of Health Plans (remote).

**MHMC Staff**: Blake Hendrickson**,** Susan Schow, Lisa Nolan, Ted Rooney, Lyndsay Sanborn, Frank Johnson, Brandon Hotham (remote), Becky Dugas (remote), Cindy Waller (remote).

**Recap of Michael Bailit’s Dec. 10th Presentation:** Frank Johnson provided a high-level recap of Michael Bailit’s presentation to the SIM Payment Reform Subcommittee. Selected slides from Michael’s presentation were reviewed to set the context for measure alignment and the major policy issues for consideration.

**Measure Context:** Ted Rooney presented a contextual view of measures by reminding participants that we continue to link payment to clinical measures which contributes roughly 20% of overall health outcomes cost while health behaviors, social and economic conditions and physical environment conditions account for the remaining 80%. Providers noted that they are reluctant to be accountable for factors that they have little, if any, control such as patients’ health behaviors. For the benefit of the non- providers Ted reminded participants of the reliance on structure and process measures, the emergence of outcomes measures and the future expansion of patient experience, functional status and risk factors.

**Preliminary Review of Measure Inventory:** Susan Schow shared her work developing a measure inventory identifying the measure source/specifications and in what setting the measures are currently being deployed in Maine (e.g., MaineCare Accountable Communities, CMS ACO, MHMC practice reports, health plans, etc.). Participants were advised that this is the very first look at the inventory and the MHMC is soliciting ideas and suggestions. Several participants expressed their appreciation for Susan’s work and there was recognition of the challenges in developing the inventory. Susan presented the measures in descending order of overlap with those measures appearing most frequently at the top. There was a very robust dialogue on formatting, content, and measure grouping (by disease/condition, etc.). Susan invited the health plans in particular to connect her with technical staff to assist in clarifying selected specifications and ensuring that the information has been captured accurately. It was noted that with changing clinical guidelines the measure set will not be static.

**Measure Selection Criteria:** Frank reviewed the measure criteria used by the NQF, the system measure criteria developed by MaineHealth and CMS selection principles as examples of criteria that may be applied to the core common measure set project. The measure alignment objectives were reviewed: common set of core measures applied consistently for contracting/payment purposes and to provide comparative reporting to inform stakeholders of performance; common set of optional measures selected to address local or organizational priorities or targeted populations.

**Proposed Multi-stakeholder Work Group:** In order to establish measure criteria, review the measure inventory against the selection criteria, identify stakeholder issues/concerns and make recommendations on a set of common measures, a work group comprised of ACI stakeholders was proposed. The proposed work group is as follows:

Health Systems (7): Eastern Maine, Central Maine, MaineHealth, MaineGeneral, Martin’s Point, InterMed, Penobscot Community Health Care.

Health Plans (5): Aetna, Anthem, Cigna, Harvard Pilgrim, Maine Community Health Options.

MaineCare

Purchasers (3): State Employee Health Commission, University of Maine System, one additional employer.

There was general agreement that the composition of the work group broadly represented the stakeholders and provides the best available vehicle to address the measure review task.

**Timeline for Measure Work:** It was proposed that beginning in late February the work group would meet monthly through June to draft a recommended common measure set(s). Frank suggested that he meet with the stakeholders over the course of the next month to identify expected issues/concerns. The intent is to inventory those issues early in the process in an attempt to resolve them to all parties’ satisfaction. A survey will be distributed to determine the most appropriate time for the work group’s monthly meetings.

**Survey of ACI Participants:** It has been suggested that the MHMC survey ACI members to identify key topics for 2014, particularly with respect to the learning collaborative role. It was agreed that the survey will be distributed within the next several weeks to facilitate 2014 planning.