**Interim Report**

**Measure Alignment Work Group**

**Charge:** The Work Group was charged with developing a common set of core measures that could be used for ACO payment and contracting purposes in an effort to advance payment reform. The stated objectives of the Work Group are:

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

**Composition:**  A multi-stakeholder work group was established under the auspices of the ACI Steering Committee. Participants included representatives of:

Health Systems/Providers

Central Maine Health – Ned Claxton, MD

Eastern Maine Health – Frank Bragg, MD

MaineGeneral Health – Barbara Crowley, MD

MaineHealth – Mark Fulton, MD

Martin’s Point – Jeff Bland and Donna Gartland

Mid Coast Health – Carl Demars, MD

Penobscot Community Health – Theresa Knowles

Independent Practitioners, Mike Szela, MD and Terry Ann Scriven, MD

Payers

Aetna – Louise McCleery

Anthem – Stephanie Parker

Cigna – Mark Still, Tiffany Pierce, MD, Rob Hockmuth, MD

Geisinger – Pam Hageny

Harvard Pilgrim – Kathy Coltin

Maine Community Options – John Yindra, MD

MaineCare – Kevin Flanigan, MD, Peter Kraut, Stephanie Martyak, Amy Wagner

Plan Sponsors

Bath Iron Works – Michelle Probert

MEA Benefits Trust – Chris Burke

State Employee Health Commission – Chris Brawn

University of Maine System – Tom Hopkins (until his retirement)

Interested Parties

Maine Quality Counts – Amy Belisle, MD

Kyra Chamberlain, Muskie School

Consultant

Bailit Health – Michael Bailit, Christine Hughes

Staff

Maine Health Management Coalition – Frank Johnson, Susan Schow, Ted Rooney

**Process:** The Work Group began its assignment by reviewing an exhaustive inventory of measures currently in use in Maine for payment or performance evaluation. From this inventory the Work Group identified approximately 54 measures with multiple payer alignment. Concurrently, the Work Group endorsed a set of measure selection criteria (see Appendix A). Early in the deliberations it was determined that the measures should be identified by the following domains and separated by adult and pediatric:

* + Chronic
	+ Preventive
	+ Behavioral health
	+ Overuse
	+ Consumer experience
	+ Health status/functional status
	+ Medication management
	+ Utilization
	+ Cost
	+ Hospital performance
	+ Care coordination

The Work Group agreed to begin the process with the review of measures currently in use by multiple payers and to exclude from consideration measures that are applicable to the Medicare population exclusively. Ultimately the Work Group invited the submission of measures not included in the original inventory. Following the initial review, Work Group participants were invited to request reconsideration for any measure which had been rejected. Measure adoption would be determined by consensus or majority if consensus could not be achieved. Upon completion of a consensus-based measure set, measures were weighted using the Buying Value tool and the measure selection criteria originally adopted by the Work Group. This exercise was designed to eliminate measures that have merit but do not meet the full range of criteria.

**Intended Use of Measure Set:** The intent is that the common measure set be used by payers as a core set of measures for ACO payment and contracting purposes. The measure set is intended to provide a level of alignment among commercial payers. Performance measures for payment and contracting would not be limited to the common set. The common measure set could be modified or supplemented based on populations (MaineCare) or areas of focus (condition specific, etc.). Payers and ACOs would agree to use the same specifications for the common measures (comprehensive diabetes care: HbA1c poor control >9.0%). Payers and providers would not be expected to be limited by the measure set nor would the entire measure set expected to be incorporated in performance provisions. It is intended to be used as a foundation to advance alignment, to reduce reporting burden, and to deliver a consistent message to providers on performance priorities.

**Findings:** The Work Group has concluded a deliberate and thorough 8-month review of measures presented for consideration. These measures are currently in use either for payment of performance in the Maine market. The Work Group identified 40 measures to comprise a common set. Those measures are categorized as:

Ambulatory = 25

Hospital = 13

Cost = 2

Additionally, there are 9 descriptive utilization measures not to be considered for payment purposes and 8 measures for monitoring-only.

It should be noted that there are clinical data measures and hybrid measures (requiring both clinical and claims data) that have been identified but which require reporting capacity not generally in place for the commercial population. The Utilization measures are considered “descriptive” and are not intended for payment or contracting purposes.

Staff evaluated the measures in relation to the selection criteria originally endorsed by the Work Group in April (see attached) and using the Buying Value tool. This process revealed three measures with relatively low scores. The Work Group decided to delete one measure, retain one measure and designate a third measure as “monitor only”.

At the Work Group’s December 8th meeting nine questions/issues were addressed:

1. **How will claims-based measures be aggregated and analyzed for commercial populations at the ACO level?**

Measures should be separately reported for Medicaid, commercial, and Medicare populations.

In order to ensure robust denominators, commercial data should be aggregated at the ACO level for payment purposes. There should be separate payer-specific reporting for each ACO for monitoring purposes.

If a measure’s sample size is sufficient for an individual contract between a payer and ACO, the parties may negotiate the use of payer-specific rates.

The Coalition should develop specification sheets for each measure that define 1) time periods, and 2) overall specifications to ensure consistency (many are HEDIS measures). Initially use SIM funds for development work; ongoing operational costs yet to be determined.

1. **What should be the timeline for measure set implementation with ACO contracts?**

The adopted measure set should be effective for 2015 measurement activity for payers and ACOs ready to adopt it.

Contracting should be phased in by payers and ACOs between 1-1-15 and 1-1-16, depending on their contract effective and renewal dates, thus giving plenty of time to deal with any operational issues.

Payers and ACOs should use selected measures from this measure set rather than similar measures. Parties are not absolutely limited by the measure set should a topic of high priority ACO/payer interest fall outside of the measure set.

1. **How will clinical data-based measures be produced?**

Previously Proposed Options for Year 1:

Option 1: Use MSSP sampling model.

Option 2:ACOs report for only those practices using a common EHR (and/or aggregation from HealthInfoNet) with the expectation that the ACO will work towards expanding the number of practices over time.

Option 3:Drop clinical data-based measures for Year 1 and add them in Year 2.

Work Group recommended that health systems and MHMC identify 5-8 clinical measures that are the most feasible for reporting in Year 1 and report to the Work Group. HbA1c is among the clinical measures to be considered.

1. **How will patient experience data be collected and aggregated?**

Proposal for CAHPS:

Option 3**:** Use practice-level data, although they may not all be ACO patients (theoretically, sufficient and representative; MaineCare uses this method).

Establish survey work group for 2015 to define implementation.

Proposed Option for HCAHPS:

A neutral party will create a weighted average ACO rate based on Hospital Compare data

1. **What steps should be taken to formalize adoption of participating payers and ACOs?**

Written letter of intended measure set use by committed ACOs and payers, the latter potentially including commercial insurers, self-insured plan sponsors and MaineCare.

Letter to include a few key points of understanding, including that payers and ACOs are willing to:

* Provide data to aggregator(s) for claims-based and clinical data-measures, and
* Incorporate these measures into their contracts with an effective date between 1/1/15 aned 1/1/16

MHMC will draft a letter of intent for review by Work Group.

1. **When, how and by whom should the measure set be revisited to consider measure set updates?**

Continue to use this Work Group for continuity.

Schedule meetings to revisit the measure set for CY 2106 and to …

* Discuss implementation issues
* Review monitor-only measure performance
* Develop a plan for patient health/ functional status measures for 2016
* Develop a plan for replacing claims-based measures with clinical data-based measures as the latter become more robust and feasible

Schedule ad hoc meetings, if needed, should national guidelines change or measure lose national endorsement

1. **How should we test the adopted measures for denominator adequacy** **at the ACO level/**

The MHMC will develop rough estimates of projected ACO-specific denominators based on publicly available HEDIS rates and ACO specific attributed populations reported to the MHMC by participating payers and ACOs.

1. **How will we handle the “monitor-only” measures?**

By mid-2015 the MHMC (or payers) will generate the monitor-only measures for performance year 2014. Measures will then be considered for inclusion in 2016.

1. **Which measures will be recommended to PTE for public reporting?**

All selected measures, that are technically feasible, will be recommended to the ACI Steering Committee for consideration by PTE for public reporting. The same recommendation will be submitted to the SIM Payment Reform Subcommittee.

All adopted measures (excluding utilization measures) will be reported, even if not selected for payment.

The Work Group considered two additional items. The updated MSSP measures were reviewed and the retinal eye exam measure was approved for inclusion in the measure set. Three measures were identified as scoring low on the Buying Value evaluation tool. One measure was approved for “monitor-only”, one measure was deleted, and one measure was approved to retain.

**Next Steps:** The interim report will be presented to the SIM Payment Reform Subcommittee for review and adoption at its December 16th meeting. The Subcommittee’s recommended action will be submitted to the SIM Steering Committee. Subsequently, The Work Group’s report will be submitted to the ACI Steering Committee at its January 20th meeting for endorsement. If endorsed by the ACI Steering Committee the Work Group’s recommendations will further be forwarded to the PTE Steering Committee for consideration of measures to be publicly reported.

**APPENDIX A**

**Criteria for Selecting System Measures \***

**Current Feasibility (NQF) -** Reasonable cost, extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

**Scientific Acceptability (NQF) –** Extent to which measure as specified produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

**“Setting Free”-** Useable across multiple settings and for different populations likely to find them useful for decision-making.

**Usability/Adaptability (NQF)** – Extend to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision-making.

**Patient Experience** – Patient’s perspective on their care, family perspective, customer perspective.

**Existing state, regional, and/or national benchmarks** – Allows comparison to similar organizations.

**Financial/Incentivization** – includes payment systems, P4P (hospital and physician based), rewards and penalties.

**Improving this measure will translate into significant changes in *value*** – Value is defined as outcomes relative to costs and encompasses efficiency. Value depends on results and is measured in healthcare by the outcomes achieved, not the volume of services delivered.

 **Durability** – Longevity of measure.

**Multi-Payer Alignment** – Maximize overlap of measures with CMS, MaineCare and commercial payers. While there may be measures selected to address a targeted population (e.g., children, elderly, etc.), effort should be sustained to align measures with public payers and commercial health plans.

\*The measure selection criteria were adapted from documents produced by MaineHealth which reflect the criteria developed by the National Quality Forum (NQF).