

Executive Office of Health and Human Services  
Quality Alignment Taskforce

October 5, 2018

***Submitted electronically to Quality.Alignment@MassMail.State.MA.US***

Dear Quality Alignment Taskforce:

Thank you for the opportunity to submit comments on the Quality Alignment Taskforce's draft report and draft measure set. We commend the Executive Office for Health and Human Services (EOHHS) for convening the Quality Alignment Taskforce (Taskforce) with the goal of defining an aligned measure set for use in global budget-based risk contracts, which include MassHealth and ACO and commercial ACO contracts. We share your concern that there is currently a lack of alignment of quality measures across public and private programs in the state, and we believe that alignment is important both to advance the population health goals of the Commonwealth and the need to reduce administrative burden on providers as the health care system moves towards incentivizing more value-based care. We offer the following comments in response to both the process of the Taskforce and the substance of the Taskforce's recommendations for the aligned quality measure set.

***Taskforce activities and lack of fidelity to recommendations***

We commend the Taskforce for elevating the establishment of quality measures that serve "the essential role of promoting high quality patient care and preventing the withholding of necessary care." For that reason, we are concerned that the Taskforce meetings thus far have not been open to the public. We recommend that future meetings of the Taskforce comply with the open meeting law in order to ensure a greater level of transparency and accountability. While our organizations did not serve as members of the Taskforce and we are thus relying on information in the Taskforce report, we are also concerned that the proposal disproportionately reflects the views of insurers on both selection criteria and measures selected for the Core and Menu Measure Sets. As a result, the needs of consumers and patients are insufficiently taken into account in our view.

Similarly, given the significant impact on patient care and public health, we additionally want to convey our concern about the short timeframe for public comment on the Taskforce report. While we are grateful that we were granted an extension to submit comments, others may not have known about the possibility of receiving an extension and may have been discouraged from responding. We would recommend that future public comment periods extend to at least 30 days in order to allow for meaningful input from the public.

We are very disappointed that a number of health plans have stated in their pre-filed testimony to the Health Policy Commission that they will not adopt the standard Core Measure Set with fidelity in every contract. If the health plans are unwilling to adopt even the Core Measure Set agreed to by

participants in the Taskforce, the state cannot begin to make any real progress toward alignment and improving population health, which was the goal of the Taskforce and the subject of Taskforce meetings over the course of the past year. We hope that the Commonwealth will recommit to holding the health care system accountable to an evidence-based approach to improving the health of the Commonwealth.

### ***Selected domains and criteria for inclusion***

We offer the following feedback on the selected domains, criteria for inclusion, and measures selected for the Core and Menu Sets. We were pleased that the Taskforce selected 16 performance measure domains that identified important areas of focus for the overall measure set. However, we have concerns about the handling of domains and measures regarding mental illness and substance use disorders and strongly recommend changes in the current proposal. While we advocate the full integration of services for mental illness and substance use disorders into the larger health system, we recognize that these health care areas are still often stigmatized and overlooked. Therefore, we urge the Taskforce to advance more focus on these areas by designating separate domains for mental illness and for substance use disorders. In addition, selecting a separate domain for opioids elevates one area of substance use disorders above others that are even more common and cause more deaths annually.

We are also concerned that the measure selection process relied on a limited number of measure sets, and it did not look at measures used by innovative programs or providers in other states. In addition, the selection criteria were very restrictive. For example, criteria 1 emphasizes “nationally endorsed” measures, thus excluding the possibility of learning from innovative measures used by providers in other states. Criteria 2 focuses on the burden of collection, with a limited exception for “patient care.” This is a much narrower scope than if the Taskforce had chosen a focus on “health,” “quality” or “quality of life,” which we argue would be more appropriate. Multiple criteria reflect a focus on “value” which implies within it a focus on cost reduction. We argue that cost is already separately measurable, and that a focus on quality and health outcomes would have been a more appropriate selection criterion. In addition, we appreciate that the Taskforce set “prioritizing health outcomes” as a criterion for the overall measure set, but the selected measures are overwhelmingly focused on process.

While we appreciate the work of the Taskforce, we are concerned that the final measure set is limited and does not fully address concerns important to consumers. We note the proposed measures, both Core and Menu, do not address a number of the performance measure domains that the Taskforce selected. For example, none of the Core or Menu measures fall into the domains of equity, social determinants of health, care coordination, patient/provider communication, patient engagement, team-based care, relationship-centered care, or health behaviors. We are very disappointed that these critical topics were pushed off to the Development Set when they are so vital to patient-centered care. The absence of rigorous, measurable attention to these particular

topics thwarts progress toward prevention – the broadest win-win priority for the health of healthcare systems and the health of people they serve.

For these important domains, we believe that rather than excluding them entirely from measurement, the Taskforce should consider promoting a number of measure concepts or measures in development as pay-for-reporting in year 1. This would allow the state to make some real progress in innovation in measurement, in these critically important domains.

### ***Additional recommendations for measure sets***

We would like to make some specific recommendations for the Core and Menu Sets. Specifically, we believe that making the depression and substance use disorder measures an either/or is not acceptable. Both topics should be mandatory in the Core Measure Set. Regarding the substance use measure, we recommend that the Taskforce replace the process measure of initiation and engagement in substance use treatment with one of the six National Outcome Measures (NOMs) focused on substance use developed and used by the Substance Abuse and Mental Health Services Administration. Regarding the depression measure in the Core Set, we urge you to recommend just the depression remission measure, which reflects the strongest outcome. We also oppose offering a choice of measures within the Core Set because it dilutes the ability to analyze results across the state and from a health equity perspective.

Separately, in the Menu Set, we urge you to include additional NOMs for mental illness and for substance use in the Menu Set, as well as the NQF-endorsed SBIRT (Screening, Brief Intervention and Referral to Treatment) measure.

While we appreciate the inclusion of a patient experience measure (CG-CAHPS), we note that CG-CAHPS may not sufficiently capture the full range of a patient's experience. To give one example, it asks about a provider's communication style, but not whether the provider actually helped to resolve the patient's problem or question. We suggest that at a minimum CG-CAHPS include the narrative component (which has been tested by MHQP and is already being utilized by a number of health care provider organizations in Massachusetts). Relatedly, we note that the Core Measure Set does not reflect the needs of many of the populations served by health care programs in the Commonwealth. For example, there does not seem to be anything specific to pediatrics or maternal health in the Core Set. We would suggest some measures specific to outcomes related to pre-term deliveries. The cost is so great to women's health and neonatal health – with negative health implications across the lifecourse – that any ACO responsible for maternity care should report an outcome not only on delivery of timely prenatal care (a process outcome), but on clinical outcomes around full-term delivery. We note that this is considered in the Development section of the report, and we encourage investment of effort in the near-term to developing a measure that addresses this broadly impactful domain.

We were pleased that a number of important measures and concepts were included in the Development Set that fall into a number of key domains, including outcomes-focused maternity care

measures. These concepts and measures also include but are not limited to: oral health, care management and coordination of services, care planning, social services screening, patient activation, patient-reported outcomes measures, and measure concepts related to health equity (stratifying existing measures by race/ethnicity, age, gender, language, disability status, etc. and stratifying measures, to the extent that data systems allow, by subpopulations). We urge the Taskforce to reexamine these measures and concepts as priority areas moving forward.

Overall, we urge the Taskforce to revisit its recommendations by focusing on the issues raised here that are essential to ensure health services in the Commonwealth deliver effective and efficient high-quality, person-centered care that results in better population health. We ask that EOHHS hold a follow-up conversation with us to discuss the recommendations made in our comments.

We thank you again for the opportunity to submit comments on the Taskforce process and draft report. Please don't hesitate to contact Alyssa Vangeli at [avangeli@hcfama.org](mailto:avangeli@hcfama.org) or 617-275-2922 or any of the undersigned organizations if you have any questions or if we can provide you with additional information.

Sincerely,



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Samantha J. Morton, JD  
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A handwritten signature in black ink that reads "Alyssa Vangeli". The signature is written in a cursive, flowing style.

Alyssa Vangeli, JD, MPH  
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Health Care For All