



September 26, 2018

Lauren Peters  
Undersecretary for Health Policy  
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Ipek Demirsoy  
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**VIA EMAIL: [Quality.Alignment@MassMail.State.MA.US](mailto:Quality.Alignment@MassMail.State.MA.US)**

RE: *EOHHS Quality Alignment Taskforce, Report on Work through July 2018*

Dear Undersecretary Peters and Ms. Demirsoy:

On behalf of the Massachusetts Association of Health Plans (MAHP) and our 16 member health plans that provide coverage to more than 2.6 million Massachusetts residents, I am writing with regard to the EOHHS Quality Alignment Taskforce's *Report on Work through July 2018*, issued for public comment on September 7<sup>th</sup>. We appreciate the state's commitment to measuring and improving quality and reducing the administrative burden associated with quality measurement reporting; however, we have some concerns related to the work of the Task Force and a mandated core measure set.

MAHP and our member plans support efforts to measure and pay for quality, including collaboration between health plans, hospitals, and the state around a common set of quality measures. However, it is vital that any measure set reflect the population served, be comprised of robust measurable data, and work for a system where high-quality health care is rewarded. With these goals in mind, we offer the following comments:

**Measure Set Alignment: Measures Should Reflect the Population Served**

We have significant concerns that the Massachusetts Aligned Measure Set (MAMS) does not include all of the Healthcare Effectiveness Data and Information Set (HEDIS) measures, given their current use in the Statewide Quality Measure Set (SQMS) and by health plans in the commercial and Medicare space. As you know, health plans are required to report on clinical performance and consumer experience through HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for National Committee for Quality Assurance (NCQA) accreditation. In fact, over 90% of health plans across the country use HEDIS to measure performance on important dimensions of care and service, and HEDIS rates are tested, validated, and audited to ensure accuracy. Given the quality and use of HEDIS measures by payers, it is vital that all HEDIS measures are included in the MAMS.

We also question the alignment potential for the MAMS given the different populations served by commercial plans/ACOs, Medicaid ACOs, Medicare, and coverage for dual-eligibles. The report notes three additional measure sets developed for use by MassHealth ACOs and Community Partners, including the MassHealth DSRIP ACO Measure set with 22 pay-for-performance measures and 28 monitoring measures, the MassHealth DSRIP Behavioral Health Community Partner Measure set with 13 pay-for-performance measures, and the LTSS Community Partner Measure Set with 8 pay-for-performance measures. In addition, as the state embarks on its Duals Demonstration 2.0 waiver request and implementation, the materials note the importance of developing distinct measure sets for the Senior Care Options (SCO) population and the One Care population. Further, without a commitment from the federal government to align their quality measures to the MAMS, providers will continue to be responsible for reporting on the same set of quality measures as they are now. We caution the state against relying on the MAMS to eliminate administrative burden at the expense of important quality improvement data.

### **Quality Data Collection: Measure Set Should be Comprised of Robust Measurable Data**

Performance incentives tied to measureable quality care continue to gain momentum in the Commonwealth and throughout the country, largely in response to rising medical cost trends, consumer directed health care, and demands by purchasers for improvements in the quality of care. In order to meet these needs, it is imperative that any measure set include measures based on nationally recognized, scientific standards and have sufficient administrative, qualitative, or medical records data to assess provider performance. We have concerns with several of the measures included in the MAMS, particularly those behavioral health measures with extremely small denominators, as they are not reliable for measurement due to small sample size and cannot be reliably used for payment due to the inability to determine actual improvement. Similarly, some of the measures included in the MAMS already have very high provider performance; requiring the use of these measures in contracts would diminish the goals of pay-for-performance improvement contracts.

We recommend that any measures included in the MAMS have, or be on the pathway to having, robust measureable data, and where possible, permit plans to get data from the electronic medical record (EMR). Measures that rely on clinical data require better data submission by providers through the EMR – medical records are a key source of data for reporting outcome measures. In addition, for patient experience measures, we strongly recommend the state utilize the NCQA CAHPS survey which health plans are required to use. Any additional surveys of the same patient population have the potential to create member abrasion.

### **Measure Set Adoption: Rewarding High-Quality Health Care**

MAHP member plans are committed to addressing health care costs and improving quality. As health plans move from traditional reimbursement models toward value-based health care, measuring value as a function of both quality and cost is necessary. MAHP plans have identified HEDIS measures endorsed by NCQA for use in provider contracts which incentivize improved quality and lowered costs. As such, we appreciate the voluntary nature of the MAMS and urge the state to keep adoption of the MAMS voluntary.

As noted in the report, adopting and implementing a new set of quality measures is an extensive process, given the length and complexity of commercial payer negotiations with providers. We are concerned that requiring health plans to reopen multi-year contracts to add in new quality measurement requirements would open the entirety of the health plan-provider contract to

renegotiations. For plans that wish to voluntarily adopt the MAMS, we recommend the state allow between 1 to 3 years for adoption, to allow the development of a baseline and benchmarking. Finally, as the state continues work on quality measurement, we recommend broader representation on the Quality Alignment Taskforce, including additional health plan participants and representatives from small and large employer groups, as it is vital to align employer and other regulatory requirements with an aligned measure set to allow resources to be focused on areas of quality that matter to both employers and consumers.

We appreciate the opportunity to provide feedback and look forward to working with you in the future on quality measurement.

Sincerely,

A handwritten signature in blue ink, appearing to read "Elizabeth A. Leahy". The signature is fluid and cursive, with a large initial "E" and "L".

Elizabeth A. Leahy, Esq.  
Massachusetts Association of Health Plans