February 19, 2013

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Center for Medicare and Medicaid Innovation

Dear Mai,

Pioneers share CMS's desire to use measures to drive organizational quality, for the overall benefit of our patients. We have committed significant resources under conditions of unusual uncertainty. We are investing heavily in EMR and data warehouse resources, as well as propagation of new workflows throughout our diverse systems. As an innovation driver, we hope to focus our capacities on the best opportunity, as well as help build better standards for the future. Mature metrics that are accurate, fair, and proven to move outcomes are incredibly important to our success.

To that end, the Pioneers listed below have collaborated to make joint recommendations regarding metrics we feel are immature or flawed, but are worth working on for future benefit. Below we lay out some broad principles, and attached provide recommendations for specific metrics of concern to us (see attached grid).

1. The metric standards must support a level playing field. If the specifications are not precise, or the underlying populations or reporting methodologies too diverse, shooting for a uniform benchmark is neither realistic nor fair. In the spirit of continuous improvement, we suggest observation initially, followed by agreement on percentage year-over-year performance improvement drivers. This allows CMS the data and time to build performance curves, while still providing Pioneers incentives to improve.

2. We believe in choosing evidence based metrics to drive change in systems behavior useful to our population. While there is strong evidence that certain conditions may predict increased risk, there is often very little evidence that risk *assessment* changes outcomes. Similarly, while some metrics are mature drivers of change in younger commercial populations, evidence for proven benefit for an elderly population peters out. The fact is, some proportion of the elderly are vital and respond well to the application of commercial performance standards, but many elders are frail. For these, the primary goal is *homeostasis*—applying performance standards in these cases may actually be detrimental. Metrics that do not have strong operational outcomes evidence for our population, while important to measure, should not be tied to performance benchmarks. We suggest data observation, and possibly a negotiated minimum goal between all Pioneers, based on anchoring data shared in a transparent fashion.

3. Aggregation methodology is important and must be carefully constructed. While particular metrics can make perfect sense as stand-alone measures, we have noted that the aggregation of related measures can be illogical and prevent creation of useful performance curves or benchmarks. For those examples, we simply ask for the metrics to be dis-aggregated and reported out separately. This will require observation status for at least the first 2 years for these measures, because GRPO reporting is already underway, and disaggregation is not possible for 2012 reporting.

CMMI and Pioneers have a profound mutual interest in driving change for improvement. Time is short, so let us immediately start talking about how to best align those interests. We have many options, including:

1) Holding metrics without good benchmarking in observation status throughout the initial three year period

2) Dis-aggregation of metrics whose aggregation methods are flawed

3) Consideration for differential weighting of certain metrics, depending on the age distribution of the cohort every year. For example, weight clinical outcome metrics more heavily in a younger population, and patient experience scores more heavily in an older one.

4) Use of collaboratively agreed upon performance drivers, such as percentage year over year growth, or use of a simple anchoring minimum standard.

5) Voluntary reporting of all electronically extractable data, to enlarge the sample size for increased analytical power.

6) Assisting CMS in building performance curves to better understand best practices under different contexts.

We very much look forward to timely and constructive discussions with you.

Sincerely,

Allina Hospital and Clinics
Atrius Health
Banner Health Network
Bellin-ThedaCare Healthcare Partners
Beth Israel Deaconess Care Organization (BIDCO)
Dartmouth-Hitchcock Healthcare ACO
Mount Auburn Cambridge Independent Practice Association (MACIPA)
Monarch HealthCare
Plus/ North Texas ACO
Park Nicollet Health Services
Partners Healthcare
Presbyterian Healthcare Services
Sharp Healthcare ACO
Steward Health Care System

(groups listed are represented by the individuals cc'd in the email message)