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Massachusetts Statewide Quality Advisory Committee

Year 3 Final Report

January – November 2014

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CONTENTS

BACKGROUND

The Massachusetts Statewide Quality Advisory Committee (SQAC) was established by Chapter 288 of the Acts of 2010, and reestablished by Chapter 224 of the Acts of 2012, *An Act Improving the Quality of Healthcare and Reducing Costs Through Increased Transparency, Efficiency, and Innovation*. Chapter 224 builds on Chapter 288 with an innovative set of market-based cost containment, health care delivery transformation and health planning activities. Chapter 224 incorporated measures to ensure that cost containment efforts would not come at the expense of accessible, high quality health care. In a system where stakeholders are being increasingly asked to make value-based health care decisions, it was recognized that improved, standardized quality information was necessary to inform those decisions.

The SQAC is comprised of a diverse group of Massachusetts health care experts, industry stakeholders, and consumer advocates, and is chaired by the Executive Director of the Center for Health Information and Analysis (CHIA). The SQAC convened in 2012 with the goal of recommending the first-ever Massachusetts Standard Quality Measure Set (SQMS), a set of measures for each health care facility, provider type, and medical group in the Commonwealth. In 2012 the SQAC engaged in a priority setting process, solicited expert testimony on high-impact areas of quality measurement, and requested measure nominations. More than 300 nominated measures targeted to high-priority areas were reviewed and, ultimately, the SQAC recommended 130 measures for inclusion in the initial SQMS.

The SQMS represents a wide range of clinical areas, including preventive health care, chronic disease management, pediatric, maternal and neonatal health, mental health, and substance abuse. It also includes indicators of efficiency, such as appropriate testing of upper respiratory infections and hospital readmissions, as well as measures of patient experience. The State Legislature mandated that the following nationally accepted measure sets also be represented in the SQMS: Centers for Medicaid and Medicare Services' Hospital Process Measures (for Acute Myocardial Infarction, Heart Failure, Pneumonia, and effective surgical care), Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS), Healthcare Effectiveness Data and Information Set (HEDIS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

This report summarizes the work of the SQAC in 2014, including the third annual recommendation of measures for inclusion in the SQMS.

THIRD YEAR MEETING CYCLE

Year 3 Process and Priorities

In 2013, the SQAC determined that it would focus its quality measure recommendations on gaps in the initial standard measure set. Building on the SQAC's 2013 priorities of behavioral health, care coordination and patient centered care, the Committee agreed to add three focus areas in which there were measurement gaps: pediatrics, end of life care and resource use/efficiency.

Based on these priorities, the first business item of the 2014 meeting cycle was to discuss the usefulness and meaningfulness of the SQMS for specific populations, such as pediatric or end-of-life patients, as well as for purposes of the set, such as specialty-specific measurement, hospital reporting and provider tiering.

Early in the year, the SQAC advised on the implementation of a process by which the public nominated quality measures for SQAC consideration. Following the measure nomination period, the SQAC completed a review of 56 publicly-nominated measures, 46 of which were explicitly related to SQAC priorities. The SQAC ultimately recommended 28 new measures for inclusion in the SQMS. In acknowledgement of a variety of measures that may be useful but are not yet ready for immediate use in public reporting, the SQAC identified the possibility of establishing a new category of measures to assess and consider in the future.

SQAC Quality Measurement Priority Areas

- **Behavioral health**
- **Care coordination**
- **Patient centered care**
- **Pediatrics**
- **End of life care**
- **Resource use/efficiency**

End-of-Life Measures

In 2014, the SQAC identified end-of-life care as a priority area for additional SQMS measures. In June, the Committee invited the Ad Hoc End-of-Life Care Workgroup to speak about the state of quality measurement in this domain, and lead a discussion of the challenges and strengths of work in this field currently. The Workgroup identified four phases of a patient's health care: 1) healthy or with reversible illness; 2) early onset, chronic conditions; 3) progressive, frequent complications; and 4) hospice eligible. During Phases 3 and 4, hospice and palliative care are often more important than chronic or curative care. However, objectively determining the onset of Phase 3 and the accountable healthcare providers is difficult. The Workgroup also pointed out the inherent conflicts many providers face as healers attempting to care for dying patients.

The Workgroup identified the "Measuring What Matters" measure set, currently under development by the American Academy of Hospice and Palliative Medicine and the Palliative Nurses Association, as a potential starting place for identifying end-of-life measures to demonstrate care quality.

Although the full Measuring What Matters set was not nominated for inclusion in the SQMS this year, some of its component measures were nominated separately and later approved. The Committee expressed interest in further evaluating the remaining measures as they mature.

Use of the SQMS for Provider Tiering

M.G.L. Chapter 176J requires that when health plans use quality measures to tier providers for their individual and small group products[1], the measures must be drawn from the SQMS. The Division of Insurance (DOI) requested CHIA's advice on the development of their regulation related to the use of SQMS measures in health plans' tiering of hospitals and physicians. In developing its advice to DOI, CHIA sought input from the SQAC to better understand payers' and providers' experience with and reactions to the use of quality measures for provider tiering to date. Staff also met with external stakeholders to learn how quality measures are currently used for tiering. Representatives from health plans, provider organizations and the DOI were interviewed to assure that broad industry experience informed the CHIA's advice.

Some of the issues that arose in discussions with stakeholders related to using the SQMS for provider tiering were whether tiering should rely exclusively on the SQMS, if it should be clear which measures should be used for hospitals versus physicians and whether the DOI should define how the measures can be used by health plans. Stakeholders also raised questions regarding whether measure specifications should be standardized.

The Committee expressed the perspective that the field of quality measurement is not mature enough to permit definition of a subset of quality measures for provider tiering or to recommend how the measures should be used. Specifically, SQAC members pointed out that process measures predominate in the field of quality measurement and, therefore, in the SQMS. Outcomes measures, which may be more useful for provider accountability and more relevant for patients, are still under development.

In spite of these realities, the SQAC recognized that many payers are currently using SQMS measures to tier providers, and that the SQMS constitutes an appropriate and, in general, adequate set for tiering of hospitals and physicians. The measures have been analyzed by measurement experts and are currently used in payment and quality improvement programs. Some SQAC members, however, expressed the opinion that it would not be appropriate to dictate how carriers could use the SQMS.

Specialty-Specific Measures

The current SQMS does not identify specialty-specific measures. Due to the importance and broad reach of primary care, acute hospital care, and post-acute care, specialist physician-level measures are less commonly used in national programs. However, the SQAC agreed that specialists make up an important component of care, and identified specialty-specific measures as a gap in the current SQMS. The Committee voted to begin with an evaluation of obstetric and perinatal measures, which is currently underway. This initiative is designed to evaluate the feasibility of adding obstetrical measures to the SQMS and potentially recommending a set of measures for the SQAC's consideration. The project will

[1] This excludes self-funded health plans such as the Group Insurance Commission.

run through March 2015, and will include interviews with stakeholders and quality experts within the Commonwealth and nationally, literature review and an evaluation of existing measures.

2014 Nominated Measures

In February, the SQAC Chair solicited nominations for quality measures from the Committee and the public. Nominations were accepted through May. All submitted measures required a formal nomination and supporting information to aid in the Committee's assessment. Supporting information included:

1. Details about the measure developer
2. Whether the measure met a SQAC priority area
3. Whether the measure is included in a nationally recognized measure set
4. Examples of programs or settings in which the measure is currently used
5. Measure methodology
6. Sources to verify the validity and reliability of the measure

This year, measure nominators were also required to include a proposed level of analysis for the nominated measure (i.e. to define the entity to which the measure would be applied).

56 measures were nominated in 2014, 46 of which aligned with the following SQAC priorities:

1. Behavioral Health
2. Pediatric Care
3. End-of-Life-Care
4. Patient-Centered Care

An additional 10 measures were nominated by staff because they are currently used in the CMS Value Based Purchasing initiative.

See Appendix A for a full list of nominated measures.

Quality Measure Assessments

The Lewin Group, in its capacity as a consultant for quality measure evaluations, assessed each nominated measure using the SQAC's Measure Assessment Tool (see Appendix B). The first step was to determine whether the measure passed the two threshold requirements of meeting a SQAC priority area and being part of a nationally recognized measure set. Lewin then assigned preliminary quantitative ratings on a scale of 0 through 4 for each of the four evaluation criteria: ease of measurement, reliability and validity, field implementation, and amenability to targeted improvement. The individual scores for the four criteria were used to calculate an average score for each measure. The average score indicated the level of confidence, based on a preliminary assessment, that the measure met the evaluation criteria and

were, therefore, appropriate for the SQMS. Assessments of all measures were subject to SQAC discussion and used to inform the final recommendation for inclusion in the SQMS.

Overall, assessment of the proposed measures was straightforward and proceeded as expected. In several cases, however, the 2014 proposed measures proved a challenge to assess. These included the clinical screening questionnaires, the Leapfrog Hospital Survey, the Hospice Item Set (HIS) and patient engagement tools.

Clinical Survey Questionnaires

Four mental and behavioral health clinical tools were nominated by a member of the provider community: the Patient Health Questionnaire (PHQ-9), the Generalized Anxiety Disorder 7-item (GAD-7), the Columbia Suicide Severity Rating Scale, and the Alcohol Use Disorder Identification Test (AUDIT). These tools are questionnaires administered to patients and are commonly and widely used in a range of settings to generate an index measure of a patient's health status or vulnerability to a health condition. Implementation of the questionnaire or the resulting patient index may be used for clinical care or internal quality improvement purposes. However, these clinical tools are not quality measures with specifications that can capture questionnaire use rates by providers or produce data that is amenable to public reporting.

The PHQ-9 tool consists of three components: a questionnaire to assess a patient's depression remission at 6 months from an initial questionnaire administration, a questionnaire to assess remission again at 12 months, and a process measure that captures the frequency with which providers use the questionnaire with patients in the target population. The SQAC agreed that the PHQ-9 is an important clinical tool but currently has limited utility and practicality for the SQMS. They did, however, agree that the PHQ-9 process measure should be added to the SQMS because data for the measure can be more easily collected and it is a priority to monitor and report on providers' utilization of assessment and diagnostic tools for depression.

Similarly, the SQAC discussed the importance of the clinical tools and their intended uses, but recognized the limitations of acquiring and reporting data from these tools that can accurately describe the quality of care that patients receive.

Leapfrog Hospital Survey

The Leapfrog Hospital Survey was nominated for addition to the SQMS. The Leapfrog survey contains a broad range of questions that address many structural and process aspects of hospital operations and care delivery. Some of the items in the Leapfrog survey were difficult to assess using the existing evaluation process and rubric. For example, the survey includes eight NQF-endorsed safe practice questionnaires that determine how a hospital prevents and mitigates patient safety events, but these questionnaires are not measures of care quality in themselves. Similarly, there are questions relating to hospital staffing and operating rooms scheduling that are not intended to measure the quality of care provided in the facility. The SQAC determined that the relevant components of the Leapfrog set could be evaluated as distinct measures, rather than the entire hospital survey being evaluated as a single measure.

Of the relevant Leapfrog items and measures, Computerized Physician Order Entry and Early Elective Deliveries are already included in the SQMS.

Hospice Item Set (HIS)

Starting in July 2014, the Centers for Medicare and Medicaid Services (CMS) began requiring that hospice programs report on a set of seven quality measures called the Hospice Item Set (HIS). Many of these measures are relatively new and the evidence to demonstrate their utility as quality indicators was often insufficient or not well developed. In the longer term, HIS is expected to be a valuable addition to the measurement of the quality of end-of-life care.

Patient Engagement Tools

Two patient engagement tools were proposed by members of the public. The first, the Use and Quality of Shared Decision-making set is a series of surveys that are administered at the Massachusetts General Hospital to patients who will receive screenings or procedural services. The other patient engagement tool, the Active Patient Engagement scale, is a single item scale used to assess a patient's confidence in managing his/her own care. Both tools posed challenges when evaluated using the SQAC's measure assessment rubric. The measures have neither attained NQF endorsement nor are part of a nationally recognized measure set, and so do not pass the SQAC's initial assessment threshold. Moreover, while the tools have value for organizational quality improvement initiatives, they are not amenable to provider performance comparisons on a statewide basis. But, because there are no evident alternative measures and patient engagement is a priority for the SQAC, theses measures were flagged for additional discussion by the Committee.

As with the mental and behavioral health clinical tools, these patient engagement tools were noted as important and aligned with Committee priorities, but were determined to be impractical as part of the SQMS at this time.

SQAC Recommendations

1. Patient Health Questionnaire (PHQ-9): The SQAC unanimously agreed to add Depression Utilization of the PHQ-9 Tool (NQF #712) to the SQMS. The Depression Remission at 12 Months (NQF # 710) and Depression Remission at 6 Months (NQF #711) components of the tool will not be added to the SQMS.

2. The SQAC determined that the GAD-7, the Columbia Suicide Severity Rating Scale, and the (AUDIT) clinical tools would be noted as important and aligned with Committee priorities, but as impractical as part of the SQMS at this time.

3. The following Leapfrog Hospital Survey items will be included in the SQMS:

    a. High-risk Newborn Deliveries (PC-03)

    b. Newborn Bilirubin Screening & DVT Prophylaxis in Women Undergoing Cesarean Section

    c. Incidence of Episiotomy

   d. Aortic Valve Replacement

   e. Pancreatic Resection

4. The following Hospice Item Set measures will be included in the SQMS:

   a. Pain Screening

   b. Pain Assessment

   c. Dyspnea Screening

   d. Dyspnea Treatment

   e. Beliefs/Values Addressed

5. The following behavioral health measures will be included in the SQMS:

   a. Post-discharge continuing care plan created

   b. Post-discharge continuing care plan transmitted to next level of care provider upon discharge: Include in the SQMS

   c. Maternal Depression Screening

   d. Depression Screening by 18 Years of Age will be included in the SQMS

6. The following pediatric measures touch on important areas of pediatric care but will not be included in the SQMS. The SQAC determined that it would like more information about these specific measures and would revisit them in the next meeting cycle:

   a. Diagnosis of ADHD in primary care for school-aged children and adolescents

   b. Developmental Screening in first 3 years of life

7. The following End-of-Life Care/Patient-Centered Care measures will be included in the SQMS:

   a. Proportion admitted to hospice for less than 3 days

   b. Beliefs/Values Addressed (if desired by the patient) – also part of the Hospice Item Set

   c. Advance Care Plan

   a. Palliative and End of Life Care: Dyspnea Screening & Management

8. The following End of Life Care/Patient-Centered Care measures will not be included at this time, but these types of measures will continue to be prioritized in the future:

   a. CARE - Consumer Assessments and Reports of End of Life

b. Family Evaluation of Palliative Care

c. Family Evaluation of Hospice Care

d. Measuring What Matters set

9. The following other recommended measures will be included in the SQMS:

    b. Cesarean Section (PC-02)

    c. Patient Safety Composite

    d. Pneumonia 30-day mortality rate

    e. Heart failure 30-day mortality rate

    f. AMI 30-day mortality rate

    g. Hospital-onset methicillin resistant staphylococcus bacteremia aureus (MRSA)

    h. Hospital-onset *C. difficile*

    i. Catheter-Associated Urinary Tract Infections

    j. Central-Line Associated Bloodstream Infection

    k. SSI Surgical Site Infection: SSI colon, SSI-abdominal hysterectomy

Changes to Mandated Measures

Chapter 224 requires four measure sets to be included in the SQMS: the CMS hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical care; HCAHPS; HEDIS and ACES, the latter was replaced in 2013 by the CG-CAHPS survey tool. These sets are subject to ongoing updates from the measure stewards. Known updates to the mandated measure sets as of October 20, 2014 include:

1. The addition of one new measure to 2014 HEDIS

    a. Non-Recommended Cervical Cancer Screening in Adolescent Females

2. The removal of two measures from the CMS hospital process measures sets

    a. Angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction (LVSD) (HF-3)

    b. Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN 3b)

Summary of Recommendations

Of the 56 measures nominated in 2014, the Committee recommended 28 be included in the SQMS.

The Committee expressed an interest in evaluating additional end-of-life measures, such as the Measuring What Matters set, as well as exploring measures of opioid addiction and patient engagement for possible inclusion in the SQMS. The Committee also reflected on the need to expand the number of outcome and patient-centered measures, as these areas of quality measurement develop.

The SQAC recognized the burden created for providers as new data collection and reporting requirements are established. In order to support reliable and consistent quality measurement, providers need time to integrate new data capture requirements into their workflows. If measures are publicly reported before providers have had the time to integrate appropriate steps into their care delivery and documentation workflows, data may be unreliable or care processes may be interrupted. There are, however, certain cases where measures are useful for improving care, but not widely used; without an expectation of future reporting, progress on these important care practices may be slower. Therefore, the SQAC may consider creating an additional category for measures which are not yet included in the SQMS but will be discussed further.

Future Work

The Committee will begin its next meeting cycle by engaging in strategic planning discussions. This may include reviewing the SQAC's role in reform-oriented initiatives in Massachusetts, as well as the mission, vision and goals that drive their recommendations. In the coming year, the Committee will also continue to identify, evaluate and consider measures with specific populations and uses for the SQMS in mind. Finally, the SQAC will discuss the extent to which measures for specialists are practical for public reporting and appropriate for the SQMS, beginning first with an examination of obstetric and perinatal quality measures.

Conclusion

Over the course of the 2014 meeting cycle, the SQAC clarified appropriate uses for the SQMS, and reviewed the largest set of new measure nominations to date. The SQAC looks forward to ongoing collaboration across the Commonwealth, including with the Center for Health Information and Analysis, the Executive Office of Health and Human Services, the Group Insurance Commission and the Health Policy Commission, as it seeks to collectively improve population health, improve care for each Massachusetts resident and reduce costs for the health system.

APPENDICES

Appendix A: Nominated Measures

Measure Name	NQF #
BEHAVIORAL HEALTH: CLINICAL SURVEY QUESTIONNAIRES	
Patient Health Questionnaire: the PHQ-9	710, 711, 712
Generalized Anxiety Disorder 7-item (GAD-7)	
Columbia Suicide Severity Rating Scale	
Alcohol Use Disorder Identification Test (AUDIT)	2152
BEHAVIORAL HEALTH: OTHER PROPOSED MEASURES	
Post discharge continuing care plan created (HBIPS 6)	557
Post discharge continuing care plan transmitted to next level of care provider upon discharge (HBIPS 7)	558
Maternal Depression Screening	1401
PEDIATRIC CARE/BEHAVIORAL HEALTH	
Depression screening by 18 years of age	1515
Diagnosis of ADHD in primary care for school-aged children and adolescents	106
Developmental Screening in first 3 years of life	1448
END OF LIFE CARE: HOSPICE ITEM SET	
Hospice Set: Dyspnea Screening	1639
Hospice Set: Dyspnea Treatment	1638
Hospice Set: Pain Screening	1634
Hospice Set: Pain Assessment	1637
Hospice Set: Patients Treated with an Opioid who are Given a Bowel Regimen	1617
END OF LIFE CARE/PATIENT CENTERED CARE	
Proportion admitted to hospice for less than 3 days	216
Beliefs/Values Addressed (if desired by the patient)	1647
Advance Care Plan	326
Palliative and End of Life Care: Dyspnea Screening & Management	
CARE - Consumer Assessments and Reports of End of Life	1632
Family Evaluation of Palliative Care	
Family Evaluation of Hospice Care	208
PATIENT CENTERED CARE	
Active Patient Engagement	
Use and Quality of Shared Decision-Making	
LEAPFROG MEASURES	
High-risk Newborn Deliveries (PC-03)	

Measure Name	NQF #
Newborn Bilirubin Screening & DVT Prophylaxis in Women Undergoing Cesarean Section	
Incidence of Episiotomy	
Aortic Valve Replacement	
Pancreatic Resection	
Abdominal Aortic Aneurysm Repair	
Esophagectomy	
OTHER MEASURES	
PC-02 Cesarean Section	471
Patient Safety Composite (PSI-90)	531
Pneumonia 30-day mortality rate	468
Heart failure 30-day mortality rate	229
AMI 30-day mortality rate	230
Hospital-onset methicillin resistant staphylococcus bacteremia aureus (MRSA)	1716
Central-Line Associated Bloodstream Infection	139
Hospital-onset *C. difficile*	1717
Catheter-Associated Urinary Tract Infections	138
SSI Surgical Site Infection: SSI colon, SSI-abdominal hysterectomy	753

Appendix B: SQAC Measure Evaluation Tool

See accompanying document

Appendix C: Standard Quality Measure Set

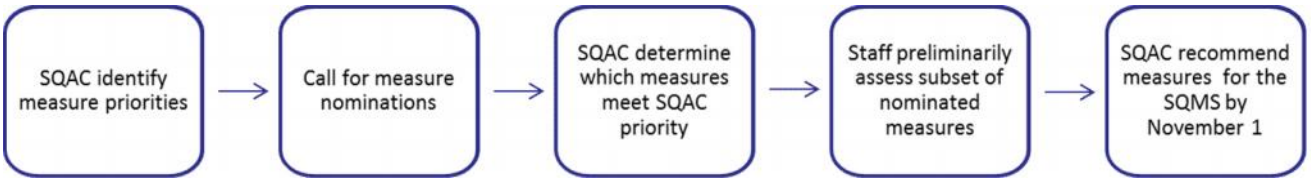
See accompanying document

Appendix D: About the SQAC

SQAC Mission

> *The Statewide Quality Advisory Committee advises all branches of state government regarding the alignment of health care performance metrics and the efficient collection and uniform reporting of the Standard Quality Measure Set in order to support improvement in the health status of the residents of the Commonwealth.*

SQAC Recommendation Process



Implementation of the SQMS

The Standard Quality Measure Set (SQMS) serves as a foundation for the uniform quality reporting CHIA is required to develop for each hospital, home health agency (HHA), skilled nursing facility (SNF) and registered provider organization (RPO) in the Commonwealth (957 CMR 4.00).

The Executive Director of CHIA determines the measures to include in the SQMS based on an annual recommendation from the SQAC. In developing the SQMS recommendation, the SQAC "shall select from existing quality measures and shall not select quality measures that are still in development" (MGL Ch. 12C, Section 14).

Mandated Uses of the SQMS

1. CHIA will publicly report hospital, HHA, SNF and RPO performance on the SQMS periodically (957 CMR 4.00).
2. Merged market carriers with >5000 enrollees must offer at least one selective or tiered plan; these plans include use of provider quality comparisons using measures in the SQMS. DOI will require uniform reporting of tiering information (M.G.L. c.176J s.11).
3. The Health Policy Commission (HPC) will develop quality standards for patient centered medical homes with reference to the SQMS (M.G.L. c.6D, s.14).
4. HPC is directed to improve the quality of health services provided through Accountable Care Organization certification, as measured by the SQMS (M.G.L. c.6D, s.15).

Appendix E: Section 14 of Chapter 224 of the Acts of 2012

The center shall develop the uniform reporting of a standard set of health care quality measures for each health care provider facility, medical group, or provider group in the commonwealth hereinafter referred to as the "standard quality measure set.

The center shall convene a statewide advisory committee which shall recommend to the center a standard quality measure set. The statewide advisory committee shall consist of the executive director of the center or designee, who shall serve as the chairperson; the executive director of the group insurance commission or designee, the Medicaid director or designee; and 7 representatives of organizations to be appointed by the governor, 1 of whom shall be a representative from an acute care hospital or hospital association, 1 of whom shall be a representative from a provider group or medical association or provider association, 1 of whom shall be a representative from a medical group, 2 of whom shall be representatives of private health plans, 1 of whom shall be a representative from an employer association and 1 of whom shall be a representative from a health care consumer group.

In developing its recommendation of the standard quality measure set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures.

The committee shall annually recommend to the center any updates to the standard quality measure set on or before November 1. The committee may solicit for consideration and recommend other nationally recognized quality measures, including, but not limited to, recommendations from medical or provider specialty groups as to appropriate quality measures for that group's specialty.

At a minimum, the standard quality measure set shall consist of the following quality measures: (1) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (2) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (3) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; and (4) the Ambulatory Care Experiences Survey. The standard quality measure set shall include outcome measures. The committee shall review additional appropriate outcome measures as they are developed.

Appendix F: List of SQAC Members

Ex-Officio Members

- Áron Boros, Executive Director, Center for Health Information and Analysis (Chair)
- Dolores Mitchell, Executive Director, Group Insurance Commission
- Kristin Thorn, Director, Office of Medicaid (Designee: Ann Lawthers)

Gubernatorial Appointments

- Dianne Anderson, President and CEO, Lawrence General Hospital (Representative from an acute care hospital or hospital association)
- Dr. James Feldman, Chair of Committee on Quality Medical Practice, Massachusetts Medical Society (Representative from a provider group or medical association or provider association)
- Dana Gelb Safran, Blue Cross Blue Shield of Massachusetts (Representative from a private healthcare plan or health plan association)
- Jon Hurst, President, Retailers Association of Massachusetts (Representative from an employer association)
- Dr. Richard Lopez, Chief Medical Officer at Harvard Vanguard/Atrius Health (Representative from a medical group)
- Dr. Michael Sherman, Chief Medical Officer, Harvard Pilgrim Health Care (Health Plan Representative)
- Amy Whitcomb Slemmer, Executive Director, Health Care For All (Representative from a health care consumer group)

Non-Voting Members

- Dr. Madeleine Biondolillo, Department of Public Health
- Kim Haddad, Executive Office for Administration and Finance
- Iyah Romm, Health Policy Commission