

**VT Health Care Innovation Project**  
**Quality and Performance Measures Work Group Meeting Minutes**  
**Pending Work Group Approval**

**Date of meeting:** April 13, 2015; 9:00 AM to 11:00 AM; 4<sup>th</sup> Floor EXE Conference Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
<b>1. Welcome; Minutes Approval</b>	Catherine Fulton called the meeting to order at 9:03. A roll call was taken and a quorum was established. A motion to approve the March minutes by exception was made by Rick Dooley; it was seconded by Lila Richardson. No exceptions were heard and the motion carried unanimously.	
<b>2. Update: Gate and Ladder for Year 2 ACO Payment Measures</b>	<p>Alicia Cooper provided an update on the status of the proposed changes to the Medicaid Gate and Ladder Methodology. The proposal went to the Payment Models Work Group in January; they considered the proposal (including input from the QPM Work Group) for several meetings, and ultimately approved an updated methodology at their March 2015 meeting. Changes to the methodology included:</p> <ol style="list-style-type: none"> <li>1) To use an absolute number of points earned rather than a percentage of points to determine where on the ladder an ACO falls</li> <li>2) To adjust the minimum quality performance standard (the “Gate”) to match the commercial standards</li> <li>3) To introduce the ability to earn improvement points based on improvement over time</li> </ol> <p>On April 1, 2015, the VHCIP Steering Committee approved the proposed changes; on April 6, 2015, the VHCIP Core Team approved the proposed changes.</p>	
<b>3. Use of Performance Measures in Blueprint-ACO Unified Community Collaboratives</b>	<p>Jenney Samuelson, Assistant Director with the Blueprint for Health, presented the information in Attachment 3, <a href="#">linked here</a></p> <p>As ACOs and the Blueprint work toward developing community health systems (Unified Community Collaboratives, or UCCs), ACO Shared Savings Program (SSP) measures that came out of this work group are being incorporated into the Blueprint quality profiles. This “Unified Performance Reporting System” will help coordinate performance reporting, create a data utility, and support quality improvement.</p> <p>Each UCC is creating a Leadership Team, including representatives from each ACO, the Blueprint, Mental Health Agencies, Home Health Agencies, Pediatrics, Housing, Area Agencies on Aging and other membership reflecting the</p>	

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	<p>community's make-up. The Team will identify community goals and convene stakeholders. The purpose is to form local work groups to review data and identify priority projects. For example, in St. Albans they are using ED utilization data to improve follow-up after ED visits and reduce admissions. Interventions include calling people the day after the ED visit and including primary care physicians in the follow up.</p> <p>The Blueprint provides comparative reports/dashboards/profiles that include both clinical and claims-based data (claims data from VHCURES and clinical data from the registry), including data for some of the ACO SSP measures. BRFSS data is also included. Health Service Area reports containing utilization, cost, and quality data (including clinical outcomes data) across ACOs and insurers are provided, as well as practice level reports. These comparative reports help identify outliers, and allow HSAs and practices that are doing well to share strategies. They also are exploring sources of clinical data that may reduce the need for chart reviews, but there is work to be done.</p> <p>Q: Is there a way to report trends over time?  A: The Blueprint plans to publish the data twice per year so that practices can see their performance over time. Benchmarks are included when available.</p> <p>Jenney described proposed changes to the payment methodology that would increase medical home payments for practices, assuming that legislative approval can be secured.</p> <p>A) A base payment of \$3.50 per member per month would be dependent on the practice achieving NCQA medical home standards AND participating in an improvement project via the UCC.  B) An additional quality payment would be based on the HSA's performance on a quality composite (including ACO SSP measures). The goal is to have those measures collected centrally instead of relying on chart reviews.  C) An additional utilization payment would be based on the HSA's performance on the Health Partners Total Utilization Index measure.</p> <p>Q: Would the HSAs receive payment?  A: No, the practices receive payment, but part of that payment would be based on the HSA's performance.</p> <p>Q: How do partner organizations get funding if they're not in the SSP?  A: The driving force is to increase support for primary care, which has been underfunded for some time. This is a transition phase (as depicted on Slide 2); the goal is to broaden support to other partners.</p> <p>Q: Doesn't the proposed payment methodology (quality and utilization components) tie payments to the work of others in the HSA over whom the provider has no control?  A: Yes; this approach supports health care reform. Certain measures will not improve without community collaboration and integration. The goal is to achieve a community-based approach to health care and quality improvement.</p>	

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	<p>Q: Will practices need to re-score within the NCQA medical home recognition program?  A: The data shows that NCQA recognition makes a difference in quality. Instead of having different payments based on the numerical score, the base payment would be the same for all practices that meet NCQA’s ‘must-pass’ elements and achieve recognition. This approach reduces overall administrative burden on practices. Practices that are currently recognized won’t have to go through recognition in advance of their scheduled date to qualify for the base payment.</p> <p>Q: As you look toward more novel funding that includes ancillary partners, does this include those who cross HSAs?  A: Howard Mental Health and one OBGYN practice are recognized under NCQA’s specialty standards – some community providers don’t have the resources to achieve NCQA recognition.</p> <p>Q: The service areas in the practice and HSA profiles don’t exactly match the Blueprint service areas.  A: The service areas in the profiles are based on hospital service areas; the only area in which the Blueprint service area differs significantly from the HSA service area is in the Eastern part of the State.</p> <p>Q: What are the preliminary thoughts about which quality measures will be chosen?  A: We are trying to keep it limited to no more than five measures and align closely with the measures identified as highest priorities. Four have been identified and there is research being conducted on whether they have adequate benchmarks. All of the ACOs have been active participants as the measures are being selected. The Blueprint and ACOs plan to attend a future QPM Work Group to obtain feedback on the measures.</p> <p>Q: Is there a plan to open the UCCs to the public and to engage the public in some of the discussion?  A: The UCC Communities are in very different places – each will have to identify how they want the UCC to form. The intent is to involve broader stakeholders (community at-large) via the leadership work groups.</p>	
<p><b>4. Green Mountain Care Board Vote on Hiatus for Year 3 Measures</b></p>	<p>The GMCB at a March meeting unanimously supported a hiatus for Year 3 ACO SSP measures. The language and the GMCB’s rationale for the hiatus is in Attachment 4, and includes the following:</p> <ol style="list-style-type: none"> <li>1) <i>To allow ACOs to focus on enhancing data collection capability and improving quality of care and health outcomes, there will be a hiatus on changes to the measure set for Year 3, unless there are changes in measure specifications or in the evidence that serves as the basis for a particular measure.</i></li> <li>2) <i>If a measure specification changes, the change would be incorporated into the measure set specifications, in accordance with “Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program.</i></li> <li>3) <i>If a measure is no longer supported by evidence, the measure should be considered for elimination. If a measure is eliminated, the VHCIP Quality and Performance Measures work group could recommend replacing it with a measure that is supported by evidence, in accordance with “Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures</i></li> </ol>	

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	<i>Used in the Commercial and Medicaid ACO Pilot Program.”</i>	
<b>5. Priority Changes and Options for Year 3 Measures</b>	<p>The group reviewed Attachment 5, a memo from Bailit Health Purchasing that outlined measure changes and options for replacing or updating those measures.</p> <p><b>Payment Measures:</b>  LDL Screening is no longer considered to be evidence-based practice; this measure should be retired. One option for replacing it is to use a statin therapy measure, but that measure has not yet been adopted by NCQA and benchmarks would not be available for a couple of years if it is adopted. Another option is to adopt one of the Medicare Shared Savings Program (MSSP) hypertension measures that were considered last year.</p> <p>Heather Skeels, Rick Dooley and others commented that inclusion of the Blood Pressure Control measure would allow the capture of blood pressure control for diabetics. They may not be captured otherwise if another measure, the Diabetes Composite Measure (“D5”), has to be dropped (that measure was dropped from the MSSP measure set, probably because it also contains the LDL screening measure). The new Diabetes Composite measure has 2 sub-measures instead of 5. The other MSSP hypertension measure (Blood Pressure Screening and Follow Up Plan) is a hard measure to collect; it requires manual chart extraction.</p> <p>Robin Edelman noted that hypertension isn’t a disease, but it is the most modifiable risk factor for a number of chronic diseases. She noted that 60% of people over 60 are hypertensive. This is an important risk factor to monitor in an aging state. She noted that even though there has been discussion of a systolic rate of 150 for older adults, the guideline has remained 140/90. A systolic rate of 150 is not supported by any group, and could result in a decline in stroke prevention and other efforts. To discuss this in more detail, the group agreed to invite Dr. Hood, a state expert on hypertension, to come to the next meeting.</p> <p><b>Reporting Measures:</b>  Regarding the D-5 Diabetes Composite measure: Minnesota Community Health is the measure steward, and they have replaced the LDL Screening Measure with a Statin Use measure. An option for this measure is to use the 3 remaining individual components in the measure (Blood Pressure Control, discussed above; Tobacco Non-Use; and Aspirin Use) Other options are to use the MSSP D2 measure, or just the Blood Pressure Control measure. The D2 measure includes the Eye Exam sub-measure. Using it for Vermont’s SSPs would reinforce ACO staff and practice staff training in collecting this measure. The more we can be consistent across payers, the better. Practices and ACOs do not provide care or participate in improvement projects based on payer.</p> <p><b>Other measure changes include:</b></p> <ol style="list-style-type: none"> <li>1) Appropriate Medications for People with Asthma has been dropped by NCQA – a good option for replacing this monitoring and evaluation measure that is collected at the health plan level is Medication Management for</li> </ol>	

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	<p>People with Asthma, which is a HEDIS 2012 measure. LaRae Francis confirmed that BCBSVT collects this measure.</p> <p>2) ED Utilization Measure is being dropped by AHRQ – there are other measures related to ED utilization in the measure set.</p> <p>3) Pending measures: LDL measure was retired by MSSP, so this group may need to consider retiring the LDL measures from the pending group as well.</p> <p>Q: Can replacement Pending Measures be added? A: Yes. Note that data is not collected for the Pending Measures.</p> <p>Q: The Board’s decision regarding a hiatus on adding new measures applies to Commercial SSP measures; what’s happening at DVHA regarding changes to the measures used in the Medicaid SSP? A: AHS and DVHA leadership is discussing what to do now – no decision has been made and the timeframe for that decision is not known at this time.</p> <p>Continued discussion of changes in measures and potential replacements for Year 3 will be on the May agenda. An updated grid with potential replacement measures will be sent out prior to the next meeting, with descriptions of numerators and denominators.</p>	
<p><b>6. Next Steps, Wrap Up, Future Meetings</b></p>	<p><b>Next Meeting:</b> Monday, May 18, 2015; 9:00 am – 11:00 am; DVHA Large Conference Room; 312 Hurricane Lane, Williston. The ACOs will share more about their Year 1 clinical data collection efforts.</p>	