

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

Date of meeting: June 22, 2015, 9:00am to 11:00 am, 4th Floor Conf Room, Pavilion Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approval of Minutes	<p>Roll call was taken and a quorum was present. Sue Aranoff moved to approve the minutes via exception; Laura Pelosi seconded the motion. The motion was approved with two abstentions.</p>	
2. Updates	<p>Project-wide convening - June 17, 2015: Georgia Maheras provided a summary of the convening that was held last week to review the Year 2 milestones, based upon CMMI’s request that the state revise its milestones. The goal was to improve understanding of the milestones and ensure they are attainable. Participants at the convening addressed questions including: How will we get there? How can we all work together to achieve these goals? Project management staff members are currently summarizing strategies and activities to achieve these milestones; that summary will be submitted to the Core Team in July. Project leadership was impressed by the participants’ engagement and candor, and expressed their thanks to participants. Cathy Fulton commented on how exciting it was to see the connections being formed between separate but related work groups and project deliverables.</p> <p>Immunization measures in IOM report: Pat Jones reported that it appears the IOM report (“Vital Signs”) is using an immunization measure for 3-year-olds that does not include all of the immunizations in the measure for 2-year-olds that is being used for Vermont’s Medicaid and Commercial ACO Shared Savings Programs. The measure in the IOM report is the same measure that FQHCs collect for UDS and is also a measure that VDH monitors, which may provide an opportunity for future alignment. It appears that there are benchmarks for the measure.</p> <p>Status of Work Group’s recommended changes to Year 2 ACO Shared Savings Program measures: Pat updated the status of changes to the Year 2 Measure Set recommended by the Work Group at its last meeting. Consistent with the Work Group’s recommendation, the VHCIP Steering Committee and Core Team unanimously approved:</p>	

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	<ul style="list-style-type: none"> • Changing the Diabetes Composite reporting measure in the Commercial and Medicaid SSPs from a 5-part measure to the 2-part measure that CMMI began using on 2015 for the Medicare Shared Savings Program (MSSP). • Eliminating the LDL Screening payment measure in the Commercial and Medicaid SSPs, and substituting it with the Controlling High Blood Pressure MSSP measure for the LDL measure. <p>On Thursday (6/25/15), the GMCB will discuss these changes for the Commercial SSP (GMCB unanimously approved the changes on 6/25/15).</p>	
3. All Payer Model Update	<p>Lawrence Miller provided a very informative presentation on the proposed All Payer Model (see attached Power Point). The Work Group had a number of questions that were discussed as follows:</p> <ul style="list-style-type: none"> • Sue asked for an update on the Blueprint funding proposal. Mary Kate Mohlman reported that a majority of the Blueprint’s Executive Committee members voted in favor of changes in practice per member per month (PMPM) rates, with 2 no votes and 2 abstentions. The Committee approved a Baseline PMPM payment of \$3.00, with an additional \$0.25 PMPM each for quality and utilization incentive payments. On Thursday (6/18/15) the GMCB approved the plan at its rate review meeting. On Friday (6/19/15) letters went to insurers describing the change. • Lawrence noted that a goal is for data and reporting to be non-duplicative. Three years is not a lot of time to develop sustainable capacity in data and reporting, and in other areas. At the end of the grant, the state will have to be prepared to let some things go and retain the most valuable interventions. How do we make sure measurements and evaluation provide rapid feedback to inform the Legislature as it is making decisions about funding on-going interventions? • Vermont will leverage the 1115 waiver; the state is working to renew the agreement at the end of 2016 in a way that is aligned with the All Payer Model. • Robin Edelman asked if the 1115 waiver would continue to cover the costs for Vermonters to participate in self-management programs. Lawrence said the decision of what to continue to fund is an on-going process both at the Agency and at the Legislature. • Sue asked whether the payments would be for all treatment provided by hospital-affiliated physicians. Lawrence responded that this is where the flexibility comes into play – these are the kinds of decisions that we need to work through. It has to be sustainable and possible – we could decide to include all hospital costs, including pharmacy. We just need to keep an eye on the trends and on designing a balanced system. A key decision is what services are to be funded through the All Payer Model. For example, if we decided to exclude costs for substance abuse treatment, we’d be excluding important costs that are driving Vermont’s health care spending right now. • The ultimate goal is to align the system with the genuine desire of providers to care for their patients. A key element in containing total cost of care is to provide transparency so that patients can choose their providers and treatment plans with knowledge about the cost and the quality of care they’re seeking. • Heidi Klein asked about quality measures – would a broader set of measures be part of the All Payer 	

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	<p>Model? Lawrence said the ACO SSP measures are the most critical measures. If we can develop a quality measurement system that is able to harvest the metrics electronically, providers will be more likely to participate.</p> <ul style="list-style-type: none"> • It is important to ensure that we have an adequate number of skilled providers willing to fully participate in the process and the model, who are willing to turn their attention to the patient in front of them and to give the patient the experience they deserve – especially in a system that constrains their clinical time in all directions. • Lila Richardson asked about the role for public input in the All Payer Model. Lawrence responded that this is a negotiation process with CMS. There are some very clear guardrails that CMS has outlined in the process. The public process will occur once the determination is made that the model will actually be a ‘good deal’ for Vermont. • There is opportunity for public input is in the performance monitoring and quality measure process. Heidi added that there are far more measures than what are included in the ACO SSP measure sets that impact cost, quality and health outcomes. • The goal is to work through the framework agreement with CMS over the next few months to get to the point at which we can design the framework for the model in more detail. The timeline is to use 2015 to build the framework, with implementation planning in 2016 and a launch of the program in 2017. • Sue referred to the process of negotiating Medicaid contracts with ACOs – e.g. Oregon is allowing ACOs to spend money on housing. To what extent will we have that type of flexibility under an All Payer Model? Lawrence responded that the goal is to build that flexibility into the system, by extending the flexibility of Medicaid spending to Medicare and commercial payers. <p>Cathy thanked Lawrence for his presentation.</p>	
<p>4. Year 3 ACO Shared Savings Program Measures</p>	<p>Year 3 ACO Shared Savings Program Measures: Robin Edelman asked about the timeline for making changes to Year 2 measures. Pat responded that the Medicaid contract amendment process is underway now and will fully incorporate the measures into the Year 2 measures set in the next month or so.</p> <p>Pat reviewed the decisions made to cardiac and diabetes measures for Year 2 – the question is whether the group wants to recommend these same changes for Year 3. Heather Skeels asked about flexibility if the measures are determined later to not be aligned with current practice. The Work Group does have ongoing flexibility to address changes of that nature.</p> <p>The motion from last meeting that resulted in recommendations to change the Year 2 measure set: was read: <i>“For Year 2 (2015) of the Medicaid and Commercial Shared Savings Programs to eliminate the LDL Screening payment measure and replace it with the Medicare Shared Savings Program Blood Pressure Control measure as a payment measure; and to eliminate the Diabetes Care Composite (“D5”) reporting</i></p>	

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	<p><i>measure and replace it with the Medicare Shared Savings Program (“D2”) measure as a reporting measure.”</i></p> <p>Diane Leach noted there are 2 blood pressure measures for MSSP. The recommended measure is Controlling High Blood Pressure. The blood pressure control measure is much more feasible to collect and measure than the other measure (screening and follow-up plan). Diane reflected concern from providers that maintaining the lower blood pressure is causing them to over-treat patients. Pat added that ACOs will be compared to national benchmarks and not to a 100% compliance rate.</p> <p>Mike Nix asked for clarity about the measure. If you get the patient to the target rate one time, is that enough? What is the point in time that is being measured? Miriam Sheehey will provide additional information; providers need additional education in order to understand the measure in their working environment.</p> <p>Heidi Klein made a motion to recommend continuation of both of the Year 2 measure changes into Year 3, by exception, as follows:</p> <p>“For Year 3 (2016) of the Medicaid and Commercial Shared Savings Programs to eliminate the LDL Screening payment measure and replace it with the Medicare Shared Savings Program Blood Pressure Control measure as a payment measure; and to eliminate the Diabetes Care Composite (“D5”) reporting measure and replace it with the Medicare Shared Savings Program (“D2”) measure as a reporting measure.”</p> <p>Heather Skeels seconded the motion. Vicki Loner asked whether the motion ensures alignment with MSSP; Pat replied that it does. Patty Launer asked about the description of the Controlling High Blood Pressure measure in Attachment 4b. Pat noted that there is a mistake in the attachment – the MSSP measure is blood pressure at or below 140/90 for all ages. The motion passed unanimously.</p> <p>M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions: The measure steward, AHRQ, is no longer supporting this measure. There are at least 3 options for Year 3:</p> <ol style="list-style-type: none"> 1) Continue to use even though it will not be supported and updated 2) Replace with Avoidable ED measure from Onpoint Health Data 3) Do not use and do not replace <p>Bailit Health Purchasing recommends using the Onpoint measure, which is also being used at the Blueprint. The measure looks at diagnoses -- such as sore throat, viral infections, ear infections, joint pain, fatigue, and headache -- that rarely result in hospitalization. Julie Wasserman asked about urinary tract infection, common in the nursing home setting. It is not included in the list of diagnoses. Diane Leach asked whether a higher diagnosis would supersede a lower diagnosis, or if a visit that resulted in an admission would be</p>	

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	<p>counted. For example, would admission after a diagnosis of headache be included?</p> <p>The measure would be collected at the ACO level. It could not initially be trended over time because the Year 1 measure would be different. Vicki Loner asked if it could be monitored in Year 2 and then included in Year 3. Pat said she thought the state could ask the contractor to perform the calculations for Year 2.</p> <p>Heidi Klein pointed out the differences between the AHRQ and Onpoint measures. Heather Skeels said that in a way, they are inverse measures. Whereas the AHRQ measure was derived from a measure of ambulatory care-sensitive inpatient use, Onpoint’s measure is geared to outpatient ED visits that rarely result in hospitalization. Except for asthma, none of the diagnostic categories across these two measure specifications have any overlap. The focus on preventable ED use supports the Triple Aim. Patty noted that the measures could provide important information about access, e.g., after-hours access to primary care.</p> <p>There were questions about whether the Onpoint measure has been tested or validated. Mike Nix proposed holding off until the August meeting to obtain more information. Diane Leach added that ICD-10 has huge implications for all these measures. Mary Kate Mohlman will ask Onpoint about the switchover of this measure to ICD-10 and for detailed specifications.</p> <p>Year 1 Measure Results: Results should be ready for the September meeting. Maura Graff asked if there is one place to find all the measures. Staff will update the Medicare/Medicaid/Commercial SSP crosswalk table and will also update the website.</p>	
<p>8. Next Steps, Wrap Up and Future Meeting Schedule</p>	<p>NOTE: The July Meeting is CANCELED.</p> <p>Next Meeting: Monday, August 24, 2015; 9:00 am – 11:00 am; DVHA Large Conference Room, 312 Hurricane Lane, Williston; Call-In Number: 1-877-273-4202, Conference ID: 420-323-867</p>	