VT Health Care Innovation Project
Quality and Performance Measures Work Group Meeting Agenda

Tuesday, November 5, 2013; 10:00 AM to 12 Noon
Office of Professional Regulation Third Floor Conference Room, City Center, 89 Main Street, Montpelier, VT
Call-In Number: 1-877-273-4202 Passcode: 9883496

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00-10:10	Welcome and Introductions		
2	10:10-10:25	Draft Work Group Charter	QPM Charter Draft 3	
3	10:25-10:35	Comments on Commercial and Medicaid ACO Shared Savings Measures	Combined measures comments ACO Measures comment summary	
4	10:35-11:00	Reporting Measures: Criteria for Attaining Full Payment	2014 Comparison… Reporting Measures Scoring Options	Yes
5	11:00-11:25	Draft Measure Modification Standard	ACO Standards draft – process for review and modification of measures	Yes
6	11:25-11:45	Measures for SIM Driver Diagram	Driver Diagram SIM Driver Diagram Measurement Categories and Goals	
7	11:45-12:00	Next Steps, Wrap-Up and Future Meeting Schedule	Proposed QPM Meeting Schedule	

VT Health Care Innovation Project
Quality & Performance Measures Work Group Meeting Minutes

Tuesday, November 5, 2013 10am to 12 noon
Office of Professional Regulation, Third Floor Conference room, City Center, 89 Main Street, Montpelier, VT
877-273-4202 Passcode 9883496

Staff: Alicia Cooper, DVHA; Pat Jones and Ena Backus, GMCB; Nelson LaMothe, UMass
In Person: Catherine Fulton, VPQHC; Laura Pelosi, MMR and VT Health Care Association; Catherine Burns, Howard Center; Paul Harrington, VT Medical Society; Susan Johnson, Northern Counties Health Care; Carol Kulczyk, VITL; Susan Onderwyzer, DMH; Allan Ramsay, MD, and Betty Rambur, GMCB; Lila Richardson and Julia Shaw, VT Legal Aid; Peter Cobb, VAHHA; Heather Skeels, Bi-State Primary Care Association; Sharon Winn, BCBSVT; Marybeth McCaffrey, DAIL; Robin Edelman, VDH; Jenney Samuelson; Blueprint.
By Phone: Anya Rader Wallack and Georgia Maheras, VHCIP; Cindy Thomas, DVHA; Norman Ward, MD, and Vicki Loner, OneCare; Michael Bailit and Kate Bazinsky, Bailit Health Purchasing; Shawn Skaflestad, AHS

Agenda Item	Discussion	Next Steps
Welcome and introductions		
Draft Work Group Charter	Document: **QPM Charter Draft 3** **Purpose:** Paul Harrington asked for more specificity in terms of who the work group will be making recommendations to and suggested that there was a tension between the group both recommending and maintaining measures. Sharon Winn indicated that she was not sure what "qualifying shared savings" means and asked for a more clear explanation in the purpose. The group also asked for an explanation of "health home". **Scope of Work :** Marybeth McCaffrey and Sharon Winn expressed concern that the WG should not limit itself to choosing from nationally benchmarked measures. Paul Harrington indicated it is premature to suggest that the work group should "revise, retire, or replace measures " since the Core Team has not met to determine its recommendation on whether measures should be fixed for 3 years, as	WG staff to revise charter based on suggestions.

Agenda Item	Discussion	Next Steps
	has been recommended by VMS. Lila Richardson expressed concern that the language did not indicate that measures could be added. Sharon Winn expressed concern about whether the focus was on measuring payers. Pat Jones advised that the language could be clarified to indicate that the measures will be used to assess the quality and performance of alternative payment and delivery system structures. **Deliverables :** Sharon Winn proposed that the Charter be richer in terms of how Q&PM WG ties in with other WG's deliverables and the overall project goals. There was a request for a visual representation of the WGs interconnectivity to one another. **Milestones :** Peter Cobb and Paul Harrington suggested deleting bullet #1 Review and recommend measure modification standard for ACO's. Marybeth McCaffrey would like to see a crosswalk of WG milestones with decisions the Core Team needs to make 12 months out. Laura Pelosi's view of best practice: as Payment Models are formally approved, the Q&PM WG should then make measure recommendations. **Member requirements:** little or no comment **Resources Available for Staffing and Consultation:** Laura Pelosi's suggested expanding Charter to include membership, title, organization, and contact info. for chairpersons and staff.	
Comments on Commercial and Medicaid ACO Shared Savings Model	Document: **ACO Measures Commentary** Pat Jones thanked those who had submitted comments on the proposed measures for commercial and Medicaid ACOs and indicated that the Core Team would take the comments into consideration.	
Reporting Measures: Criteria for Attaining Full Payment	Document: **Uses of Reporting Measures in Shared savings Distribution Determination** Focus of the group was on Options #3, #4, and #5 since most agreed that the focus should be on incentives for reporting, not penalties. Lila Richardson expressed concerns about #2 because it doesn't tie the failure to report to barriers of any kind. Paul Harrington relayed that the Medical Society and Fletcher Allen have recommended that 6 of the payment measures be moved to the reporting category; that care incentives are all tied to reporting not performance; and strongly	WG Staff to revise Option 4 and circulate to the work group to review by e-mail; the goal is to be able to provide a

Agenda Item	Discussion	Next Steps
	recommended that option 5 not be considered because many small providers do not have capacity/resources to access and report the measures. Pat Jones indicated the HIE Performance Measures Subgroup is evaluating measurement capacity. Carol Kulczyk relayed that VITL is recommending a more detailed analysis of EHRs and the time needed to develop electronic reporting capacity (e.g., small practices may need 30 RN hours/1000 patients to assess EHR measurement capacity). It was suggested that a gap analysis in terms of reporting capacity should be conducted before there are penalties for failure to report. Allan Ramsay indicated that penalties in early years are significantly less productive than incentives. Option #5 is not ideal at this time since the GMCB does not have appropriate information to assess and act on the barrier analyses submitted. Norm Ward asked for more information on Option 3 and suggested that a concrete example of the point calculation be provided. Sharon Winn indicated that health plans already report claims based measures and some of the clinical based measures and could potentially generate proxy reports for providers lacking resources/capacity. Jenney Samuelson suggested merging Options #3 & #5. Robin Edelman noted that it is important to think of the total health perspective and the need to educate providers about the importance of being able to report the data that is necessary for understanding the health of the population. Laura Pelosi summarized the discussion. The group agreed that if there was no change in the Year 1 reporting and payment measures, they could recommend a revised version of Option 4. Staff will redraft Option 4 based on the comments received, and circulate it by e-mail for work group review and comment. The goal is to provide the recommendation to the Core Team for its November 18 meeting. Anya and Alicia expressed concern that any further delay in recommending a preferred Option will impact the contracting and implementation for ACO's effective 1/1/14.	recommendation for Core Team review at its November 18 meeting
Draft Measure Modification Standard	Document: **ACO Standards Draft** Deferred until next meeting.	Hold to review at next meeting.
Measures for SIM Driver diagram	Documents: **Driver Diagram,** and **SIM Driver Diagram Measurement Categories and Goals** Pat Jones presented the Draft Driver Diagram and SIM Driver Diagram Measurement Categories and Goals. Pat explained the three main aims (improve care, improve health, reduce costs) and the primary drivers to reach those aims. Pat explained that she had bucketed the proposed Commercial and Medicaid ACO measures under each of the three aims and noted that in the	

Agenda Item	Discussion	Next Steps
	future when the group develops additional measure sets that these will also be categorized under the three aims. Paul Harrington noted that the Driver Diagram reinforces the concept of having a stable set of measures over the three years of the project so that progress can be assessed year over year, rather than looking at performance on additional or different measures in subsequent years.	
Next Steps, Wrap-up, and Future Meeting Schedule	Document: **Meeting Schedule** Next meeting scheduled for Thursday Dec 12 10am-noon. Meetings going forward will be the 3rd Monday of the month, 10am to noon, with a few exceptions. Locations tba, but likely to be City Center, 89 Main St., Montpelier.	

AGENDA ITEM #2

Vermont Health Care Innovation Project
Quality and Performance Measures Work Group Charter

DRAFT

PURPOSE

The purpose of the Quality and Performance Measures Work Group is to develop, recommend, and maintain a standard set of quality and performance measures in order to evaluate the performance of Vermont's payment reform models relative to public policy goals; qualify and modify shared savings, episodes of care, pay for performance, and health home payments; and communicate performance to consumers through public reporting.

SCOPE OF WORK

- Develop criteria and expectations for measure selection.
- Review nationally accepted measures that can be benchmarked.
- Develop consolidated and standardized sets of all-payer quality and performance measures.
- Troubleshoot measurement collection and reporting barriers and support measurement issue resolution.
- Review performance measures on at least an annual basis and determine measures to be revised, retired, or replaced as appropriate.
- Learn about, inform, and integrate relevant activities of other Vermont Health Care Innovation Project (VHCIP) work groups.

DELIVERABLES

- Review selection criteria used to develop ACO shared savings measures and expand to episodes of care, pay-for-performance, and other payment models adopted for testing, as appropriate.
- Recommend how measurement should impact payment, as appropriate.
- Review and recommend measure review and modification standard for ACO shared savings measures.
- Review, modify, and recommend measures for SIM Driver Diagram.

- Review and recommend potential modifications to the Vermont Oncology Project Quality and Performance Measures.
- Develop recommended measure sets for other payment models that are adopted for testing.
- Report on and recommend measures to be revised, retired, or replaced as appropriate, on at least an annual basis.

MILESTONES

Winter 2013-14:

- Review and recommend measure modification standard for ACO measures.
- Review, modify, and recommend Measures for State Innovation Model (SIM) Driver Diagram.
- Review and recommend potential modifications to the Vermont Oncology Project Quality and Performance Measures.

Spring 2014:

- Recommend selection criteria for the development of measures for episodes of care and pay-for-performance models.
- Begin to develop measure sets for additional payment models, as those models are adopted for testing.

Winter 2014-15

- Report on and recommend ACO shared savings measures to be revised, retired, or replaced.

MEMBERSHIP REQUIREMENTS

The Quality and Performance Measures Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Members are expected to communicate with their colleagues and constituents about the activities and progress of the work group and to represent their organizations and constituencies during work group meetings and activities.

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Catherine Fulton, Executive Director, Vermont Program For Quality in Health Care
- Laura Pelosi, MacLean, Meehan & Rice

Work Group Staff:

- Pat Jones, Green Mountain Care Board
- Ena Backus, Green Mountain Care Board
- Alicia Cooper, Department of Vermont Health Access

Additional resources may be available to support consultation and technical assistance to the work group.

Commenter	Comment Summary
Betsy Davis, RN, MPH	Add in a measure to collect data related to memory screen. Data source: Medicare tracks this since it is reimburseable. Rationale: With the increase in the over 65 population and considering the fact that early diagnosis and treatment can delay cognitive decline, it seems important to encourage PCPs to have memory screens as part of their yearly wellness visit, and collecting the data would therefore be useful.
Vermont Information Technology Leaders	Concern: whether we can capture the measures in electronic form and in a complete and accurate manner. Recommendation: Trade-off between the value of performance measures versus the cost and complexity of obtaining the data. Assess each provider organization's ability to collect the data pertinent to the measures and selecting the measures based on a comparison of the value of the measure versus the complexity and cost of collecting them.
Fletcher Allen Health Care	Main points: • Use measures that are actionable • Use measures that drive the improvement that we are looking for across our state • Use measures that are easily validated and do not require extensive chart review • Pick a number of measures that is manageable • Do not change the measures or add new additional measures for at least 36 months • Focus the measures on improving the health of our population Measures to be included in "pay for reporting" and that the individual metric data associated with them not be used for determining achievement in the shared savings formula – outside of the act of reporting them – until the ramp-up of these measures is reasonably accomplished across the provider network in Vermont. • Depression Screening by 18 • Developmental Screening in first 3 years of life • Chlamydia screening in women • Avoidance of antibiotic treatment for adults with acute bronchitis • Initiation and engagement of alcohol and other drug dependence treatment • Follow-up after hospitalization for mental illness (7 day)

MVP Health Care	MVP supports the measures developed collaboratively by the stakeholder workgroup. MVP believes it would not be advisable to go back and change them so late in the process as this could delay implementation.
Accountable Care Coalition of the Green Mountains	Concern: Medicare SSP reporting is arduous and resource intensive. Concern: The MSSP and the proposed SIM ACO programs come with absolutely no funding for practices to carry on ACO required measurement and reporting activities, nor are there any guarantees that there will be eventual savings. The more measures, the higher the risk of failure to recoup the significant resources invested in the programs. Recommendation: While agree that choosing claims based measures means they are less onerous to report, concern is that the measures selected are not necessarily the most important clinical issues to address, and therefore will receive an inappropriate excess force of attention, drawing resources away from more meaningful clinical matters. Suggest additional clinical discussion regarding the clinical utility of these measures. Apply this to a smaller number of measures. Recommendation: A limited number of maternity and pediatric measures should be added to the MSSP measures, for both the Commercial and Medicaid pilots, and the full set of measures be used for the three years of the program. These pediatric and maternity measures should be vetted by experts in maternal and child health as important to common clinical outcomes, and easy to measure. The list of "for reporting only" measures should be substantially reduced. Recommendation: Each unique measure in these SIM ACO programs should be accompanied by reasonably accurate descriptions of the financial resources needed to retrieve and report the data; and furthermore, the responsibility for funding the collection and reporting should rest with the SIM program / Insurers themselves, not with the providers.
Vermont Legal Aid Office of Health Care Ombudsman	Focuses primarily on the importance of fostering a strong consumer focus in the ACO model, which includes ensuring that health care quality improves at the same time that shared savings are earned. Concern: The Payment Measures subset of Core Measures is too small to effectively measure overall quality or to provide consumer protection over the three-year demonstration period. With so few Payment

	measures, improved quality in these few areas may not be reflective of the level of care provided to all ACO patients. This is especially a concern because the Payment Measures subset does not include any measures in the domains of Patient Experience, Pregnant Women, Elderly & Disabled or End of Life Care. Recommendation: Add in additional measures, including those that ensure excellent preventive care. Rationale: Quality measures are one of the only ways to protect consumers against providers taking to under-serving as a means of achieving savings. Payment tied to high quality performance serves as a counterbalance against such an approach. A Core Measures set with fewer than ten Payment measures, risks severely diminishing the effectiveness of that counterbalance. Concern: Over-emphasis on the criteria that measures "not be administratively burdensome." The reality is that ACO participation is voluntary, and some administrative burden is necessary in order for ACOs to be *accountable* to their patients. Recommendation: The Core Team dedicate significant resources to improving the collection and transferability of measures-related information. This would allow for expansion of the Payment measures subset, and better quality monitoring with less burden to providers, in years two and three of the demonstration. Concern: The Core Measures set must be expandable throughout the demonstration period. Specific concern around quality of assessing Duals, those who need LTSS. Recommendation: Strongly support clear language in the Process for Review and Modification of Measures Standard to provide for the addition of new measures to the Core set to include LTSS in years 2 and 3. Additional Point: The overall size of the Core Measures set is not too large. We are aware that some Steering Committee members believe that the Core Measures set is too large and onerous for providers. We strenuously disagree. There may be too few measures to adequately monitor the scope of care provided to specific populations. Medicaid and Commercial ACOs will encompass a much broader spectrum of Vermonters, and more measures are needed to assess the quality of care provided to all those served by the ACOs.

	Recommendation: We would support including the two Medicaid pediatric measures for the commercial population. Concern: There are neither Payment nor Reporting measures targeted to pregnant women, and the only women's health Payment or Reporting measures at all are for Chlamydia Screening and Breast Cancer screening. Concern: It is unclear what role the Reporting Measures will play in the calculation of shared savings, if any. Several proposals currently under consideration by the newly reconstituted Quality and Performance Measures Work Group would allow ACOs to avoid collecting and reporting on at least some percentage of Reporting measures. These types of gaps in reporting should be kept to a minimum. The ACOs should be required to report all of the Reporting Measures unless they can demonstrate extraordinary circumstances that make it impossible for them to do so. *Note there are other concerns raised regarding the gate and ladder structure of the ACOs. These are not included in this document.
Blue Cross Blue Shield of Vermont	Supports the measure set as presented at the Steering Committee meeting in October. Rationale: The group endorsed 38 clinical measures, 26 of which are also MSSP measures. The additional 12 measures cover clinical areas that otherwise would not be addressed, including pediatric care, MHSA care, and overuse of antibiotics. Given the challenges we have in Vermont in all three of these areas "I'm hard-pressed to understand why" we would not include these measures in assessing ACO progress. Of the 38 total measures, only 7 are included for commercial payment in 2014, a number so low that in many forums it will be hard to defend. Supports reviewing the additional 31 clinical measures, and several patient satisfaction measures because they are important guideposts for our future work.
Vermont Medical Society	Concern: The addition of 21 new measures, on top of the 33 existing Medicare measures, would create a total of 54 ACO accountability measures and it would impose too great an administrative burden for physicians. Physicians are not going to differentiate between the sources of payment with respect to the clinical care they provide to their patients and would feel accountable for all of the relevant 54

	measures. Concern: Such a large number of measures would make targeted quality improvement activities extremely difficult. Recommendation: The addition of a limited set of relevant and easily reported pediatric and maternity measures to the existing 33 Medicare measures in order to create the Commercial and Medicaid ACO measures set. Rationale: Implementation of ICD-10 on October 1, 2014; the implementation of Stage II of Meaningful Use on January 1, 2014 and the implementation of Medicare's Value-Based Modifier on October 15, 2013 for physician groups over 100, 2014 is going to be especially challenging for physician due to these new federal mandates. Reporting these HEDIS measures is complex and hasn't been done well in the past. Recommendation: Reclassify the following 6 commercial and Medicaid ACO measures from payment to reporting: 1. Follow-Up After Hospitalization for Mental Illness (7 day) 2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 3. Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis 4. Chlamydia Screening in Women 5. Developmental Screening in First 3 Years of Life 6. Depression Screening by 18 Years of Age Recommendation: Maintain the stability of the measure set for the entire three years of the Commercial and Medicaid ACO pilot. Recommendation: Due to the high degree of uncertainty the process described in paragraphs 3 and 4, on pages 13&14, would create regarding adding new measures to the measure set for the second and third years of the three year pilot, the VMS recommends the deletion of paragraph 3 and 4 on pages 13 and 14.
Bi-State Primary Care Association	Bi-State supports the Year 1 measure set developed through many compromises by the ACO Measures Work Group. Concern: The size of the measure set, especially the many pending measures that may add more burden to the measure set over the years. We expect that we will advocate to delay implementation of additional measures until the burden of reporting and improving quality on the Year 1 measures is fully understood.

	Concern: Some of the payment measures have no 2012 benchmarks. Recommendation: If no valid benchmarks can be identified, Bi-State would recommend that these measures be characterized as reporting measures in Year 1 so that benchmarks can be developed. *Note they have concerns around the scoring methodology that are not included in this summary.
Bob Bick, Howard Center	Concern: Surprised that while there are measures for tobacco use screening, depression screening, and high blood pressure screening there does not appear to be a comparable screening expectation for alcohol & drug use. There is an "initiation and engagement measure" but if I understand that correctly, that would be for folks who somehow have already been identified and their compliance with engagement is being measured. If I misunderstand, please advise. If not, and given the known impact of untreated alcohol and/or drug abuse/dependence on healthcare costs I would suggest that a screening measure be expected.
Julie Tessler, Executive Director, Vermont Council of Developmental and Mental Health Services	Designated agencies raised a number of questions related to access to data, ability to report, the relationship between screening tools and clinical practice, the appropriateness of measures, implications for practice, which members of the population they would be accountable for, and regional variations in the health care landscape.

AGENDA ITEM 3B

From: Jones, Pat
To: Maheras, Georgia
Subject: FW: Questions on Quality Measures
Date: Friday, November 01, 2013 4:21:20 PM
Importance: High

Georgia,
Can you add this to the Measures Comments pdf? Our co-chairs correctly noted that this e-mail should be included in the comments. Thanks very much!

Pat Jones
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From: Tessler, Julie [mailto:Julie@vtcouncil.org]
Sent: Friday, October 25, 2013 4:17 PM
To: Geiler, Christine; Jones, Pat
Subject: Questions on Quality Measures

Questions from the VT Council on quality measures:

1. ACCESS AND REPORTING: How will we handle agencies that (a) don't have a developed or functional EHR (either slow or dated technology), and/or (b) don't have access to VITAL. There is a huge discrepancy between agencies here that is very problematic.
2. ACCESS AND REPORTING: As a DA, what is our level of responsibility for reporting and monitoring the reporting of medical outcomes (particularly if we don't have access to VITAL)? What if they get their health care from another ACO? How would this information be reported back and forth in an efficient way?
3. SCREENING TOOLS AND CLINICAL PRACTICE: Screening for depression – all of these screens (according to our medical director_ were developed by drug companies and they don't look at functional recovery, which seems to be the goal here. Where is the evidence that screening leads to functional improvements?
4. SCREENING TOOLS AND CLINICAL PRACTICE Screening may or may not ensure good care. How will this be coordinated between providers to ensure that quality care ensues?
5. APPROPRIATENESS OF MEASURES: Some of the outcomes are based on process measures and not on outcomes (e.g., decreased mental health hospitalizations)? What do we really want to know?

6. ACCESS AND REPORTING: Follow-up after hospitalization – how will they get this data? Claims data may not reflect the full range of services that are provided (e.g., discharge planning while in the hospital) and it seems that a chart review would be needed to obtain accuracy.
7. WHO ARE WE ACCOUNTABLE FOR? Who would be considered our client? For instance, if we see someone for a crisis event and have one follow up, does this mean that we are then responsible for all of the reporting for the outcomes for their care?
8. FOLLOW – UP: How can we know if they are getting appropriate primary care? Particularly if they are seen outside of our ACO?
9. ACCESS AND REPORTING: How will they check and/or omit individuals who refuse care?
10. ACCESS AND REPORTING: What is the role of the community health team in the ACO so that one provider doesn't have to do it all? How will this work in communities where this team does not exist?
11. ACCESS AND REPORTING: We need more universal access to information across providers to make this work.
12. IMPLICATIONS FOR PRACTICE: The current outcomes would require DA's to greatly expand their medical staff thus drawing funds away from other services.
13. ACCESS AND REPORTING: What level of documentation is required to demonstrate compliance? Can this level of detail be adequately achieved in the current EHR system located within the DA or SSA?
14. SCREENING TOOLS AND CLINICAL PRACTICE: What about individuals who have developmental disabilities? Do these measures apply to them?
15. SCREENING TOOLS AND CLINICAL PRACTICE: Meaningful use issue. Prompts to collect data are helpful but no always clinically appropriate. For instance, psychiatric staff see clients much more often than primary care does. Does it make sense for them to be collecting this data? At what frequency? Is it meaningful to their work and/or good use of their (the clinician and the client's) clinical time?
16. APPROPRIATENESS OF MEASURE: We need to have a voice in the development of the measures regarding patient experience to make sure they are relevant to the community mental health environment.
17. HEALTHCARE LANDSCAPE: There could be large variation here in appearance of compliance depending upon the presence and type of hospital in the area being served. For instance, in Chittenden County, the vast majority of health care is provided by FAHC or their affiliate. It does not make sense to bring primary care to HC.
18. SCREENING AND PRACTICE: And, if you find a positive screen, it does not mean that all follow up care is covered by insurance. For instance, nutritional counseling is only covered if someone is diabetic. If someone is obese, they have to pay for this type of counseling out of pocket.

Tthanks you,

Julie

Julie Tessler
Executive Director
Vermont Council of Developmental and Mental Health Services
137 Elm Street
Montpelier, VT 05602
Office: 802 223-1773 Cell: 802 279-0464

From:	Jones, Pat
To:	Maheras, Georgia
Cc:	Slusky, Richard
Subject:	FW: Bi-State comments on Measures/Scoring
Date:	Friday, October 18, 2013 11:51:16 AM

Bi-State submitted these comments on the measure set last Friday; I'm assuming that you would want to include with the other comments you receive.

Pat Jones
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From: Kate Simmons [mailto:ksimmons@bistatepca.org]
Sent: Friday, October 11, 2013 12:51 PM
To: Slusky, Richard; Suter, Kara; Jones, Pat; Kate Bazinsky
Cc: Susan Barrett; Lori Real; Andrew Principe; Heather Skeels
Subject: Bi-State comments on Measures/Scoring

Dear Richard, Kara, and Pat,

Bi-State supports the Year 1 measure set developed through many compromises by the ACO Measures Work Group. Our members remain concerned about the length of the measure set, especially the many pending measures that may add more length and burden to the measure set over the years. We expect that we will advocate to delay implementation of additional measures until the burden of reporting and improving quality on the Year 1 measures is fully understood. However, on the whole, Bi-State is satisfied with the Year 1 measure set and especially commends DVHA's willingness to listen to concerns about the burden, to understand the value of alignment, and compromise accordingly.

Bi-State has some questions and feedback pertaining the scoring of measures:

- We remain concerned that the methodology for scoring the achievement of the reporting measures has not been defined. It will be an achievement and a lot of work for each ACO to report on the multitude of reporting measures in Year 1. Bi-State would not support the scoring of reporting measures to be an all or nothing pass/fail. Bi-State would suggest that these measures each be worth 1 point (thus to be weighted less heavily than the payment measures), and that successful reporting of each measure would earn the ACO 1 out of 1 point. These points would be added to the numerator and the denominator of the % of eligible points, thus tying % of earned savings in a small degree to successful reporting in Year 1.
- We are also concerned that some of the payment measures have no 2012 benchmarks. If no valid benchmarks can be identified, Bi-State would recommend that these measures be characterized as reporting measures in Year 1 so that benchmarks can be developed.

Bi-State would also request the development of an appeals process if the ACO believes that its quality score should be different from the score determined by contractor. For example, would it be possible for the ACO to use clinical data to enrich the claims data (e.g., to prove that exclusions might apply for certain patients)? It is our understanding that the HEDIS benchmarks would contain some level of clinical enrichment because the insurers sometimes perform chart pulls, etc., for just this reason.

Please let me know if you have any questions about any of the above feedback.

Best,
Kate

Kate Simmons, MBA/MPH
Deputy Director, VT Programs and Policy
Bi-State Primary Care Association
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802-223-2336 (fax)

TO: SIM Core Team
FROM: Paul Harrington, EVP, VMS
RE: Request for reclassification of 6 of the proposed Commercial and Medicaid ACO measures and request for the deletion of paragraphs 3 and 4 on pages 14 and 15 in the document entitled "Vermont Commercial ACO Pilot, Compilation of Pilot Standards, October 10, 2013 Draft"
DATE: October 22, 2013

OneCareVT and the ACC of the Green Mountains participation agreements in implementing their Medicare MSSP ACOs require the use of 33 quality measures that physicians and other health professional will be held accountable for. There are 26 clinical measures and 7 patient satisfaction measures. Of the 26 clinical measures, 19 will be used to help determine the level of any shared savings.

On October 16, staff from the GMCB presented to the SIM Core Team the ACO measures workgroup's recommendations on a set of quality measures that physicians would accountable for beginning in 2014 under the proposed BCBSVT and MVP commercial plan ACOs and the Medicaid ACO. In addition to the 33 Medicare MSSP measures, the proposal before the Core Team was to add 21 additional measures: 12 clinical measures and 9 patient satisfaction measures. Of these 12 clinical measures, 8 would be used to help determine the level of any shared savings.

During the October 16 SIM steering committee meeting, on behalf of the VMS, I objected to the proposed Commercial and Medicaid ACO measure set for the below stated reasons.

The addition of 21 new measures, on top of the 33 existing Medicare measures, would create a total of 54 ACO accountability measures and it would impose too great an administrative burden for physicians. As I stated during the meeting, physicians are not going to differentiate between the sources of payment (Medicare, BCBSVT, MVP or Medicaid) with respect to the clinical care they provide to their patients. Physicians would, therefore, feel accountable for all of the relevant 54 measures. In addition to the added burden, such a large number of measures would make targeted quality improvement activities extremely difficult.

VMS recommendation 1: The VMS supports the addition of a limited set of relevant and easily reported pediatric and maternity measures to the existing 33 Medicare measures in order to create the Commercial and Medicaid ACO measures set.

With the implementation of ICD-10 on October 1, 2014; the implementation of Stage II of Meaningful Use on January 1, 2014 and the implementation of Medicare's Value-Based Modifier on October 15, 2013 for physician groups over 100, 2014 is going to be especially challenging for physician due to these new federal mandates. The VMS believes that state government should be making every effort to reduce the administrative burdens for Vermont physicians instead of significantly increasing the ACO quality reporting demands on physicians beyond those required by Medicare.

The majority of the proposed Commercial and Medicaid payment measures are almost all HEDIS measures that relate to BCBSVT's and MVP's NCQA scores. The BCBSVT/MVP HEDIS

scores for these measures have been low due in part to the complexity in reporting these measures. This very complexity of reporting is an additional reason not to use many of the proposed measures for payment purposes.

VMS recommendation 2: In order to help partially address these concerns, the VMS requests that the Core Team reclassify the following 6 commercial and Medicaid ACO measures from payment to reporting:

1. Follow-Up After Hospitalization for Mental Illness (7 day)
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
3. Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
4. Chlamydia Screening in Women
5. Developmental Screening in First 3 Years of Life
6. Depression Screening by 18 Years of Age

The Compilation of Pilot Standards October 9, 2013 Draft in Section VI.(II) (Step 6) (1) on pages 14 states: "[I]n the interest of maintaining the stability of the measure set, the Year 1 Payment and Reporting measures will not be modified for Year 2 unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines."

The VMS believes this stated interest in "maintaining the stability of the measure set" is sound policy and we feel it should be extended for the entire three years of the Commercial and Medicaid ACO pilot. In a manner similar to Medicare's policy, physicians and other health professional should have the assurance that they will be accountable for a specific set of measures over the three years of the pilot and not be faced with the possibility of new measures being added in the second and third years.

Paragraphs 3 & 4 on pages 14 and 15 of the Compilation document calls for the SIM Quality and Performance Measures Work Group to review all 22 measures designated as Pending in the Core Measure Set beginning in the first quarter of each pilot year and for it to review will review state or insurer performance on all 23 Monitoring and Evaluation measures during the third quarter of each year. Following its review of the 22 pending measures and the 23 Monitoring and Evaluation measures, if the work group determines that a measure has the support of the Work Group and is ready to be implemented in the next pilot year, it shall recommend the measure as either a new Payment or Reporting measure.

VMS recommendation 3: Due to the high degree of uncertainty the process described in paragraphs 3 and 4 of the document would create regarding adding new measures to the measure set for the second and third years of the three year pilot, the VMS recommends the deletion of paragraph 3 and 4 on pages 13 and 14 of the document entitled "Vermont Commercial ACO Pilot, Compilation of Pilot Standards, October 10, 2013 Draft.

Please let me know if you have any questions or if I can be of further assistance.

VERMONT INFORMATION TECHNOLOGY LEADERS

October 23, 2013

To: Georgia Maheras
Project Director
Vermont's Health Care Innovation Project

Thank-you for the opportunity to comment and provide recommendations regarding the proposed ACO Performance Measures.

While we appreciate that the ACO Performance Measures represent targets for performance improvement, our concern is the ability to capture the measures in electronic form and in a complete and accurate manner. Based on our experience with gathering data in support of the Blueprint for Health, there is a wide variation in providers' ability to accurately capture and report. This variability exists because entering data is based on a practice's work flow and practice patterns rather than its use for data aggregation and performance reporting purposes.

We recommend that the trade-off between the value of performance measures versus the cost and complexity of obtaining the data be evaluated.

This should be performed by assessing each provider organization's ability to collect the data pertinent to the measures and selecting the measures based on a comparison of the value of the measure versus the complexity and cost of collecting them.

Sincerely,

John K. Evans MHA, FACHE
President/CEO

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Montpelier, VT 05602
802-223-4100 www.vitl.net

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Don C. George
President and Chief Executive Officer

October 23, 2013

Via electronic mail to Georgia.Maheras@state.vt.us

Dear Georgia,

Thank you for the opportunity to write in support of the ACO reporting and payment measures developed earlier this year as part of a broad work group. As you know, BCBSVT maintained representation on both the measures work group and the standards work group. It is my understanding that a joint session of the two work groups approved the measures to advance to the steering committee of the Vermont Health Care Innovation Project. My team has kept me abreast of the work over the nearly nine months of effort, and I appreciate the opportunity to let you know BCBSVT supports the measure set as it was presented to the steering committee. I am sorry I was not able to participate in the meeting earlier this week and express our support in person.

The group endorsed 38 clinical measures, 26 of which are also MSSP measures. The additional 12 measures cover clinical areas that otherwise would not be addressed, including pediatric care, MHSA care, and overuse of antibiotics. Given the challenges we have in Vermont in all three of these areas I'm hard-pressed to understand why we would not include these measures in assessing ACO progress.

Of the 38 total measures, only 7 are included for commercial payment in 2014, a number so low that in many forums it will be hard to defend. I take some comfort in knowing that there are an additional 31 clinical measures we will at least be looking at, and several patient satisfaction measures. The extra measures are important guideposts for our future work.

Again, thank you for the opportunity to provide support.

Sincerely,

Don George

P.O. Box 186 • Montpelier, VT 05601-0186
Corporate Office (802) 223-6131 • FAX Number (802) 229-0511

From: Little, William
To: Maheras, Georgia
Subject: Comments on Shared Savings Measures Sets
Date: Wednesday, October 23, 2013 12:45:30 PM

Georgia- On behalf of MVP Health Care, I'd like to go on record as supporting the measures developed collaboratively by the stakeholder workgroup. I also believe it would not be advisable to go back and change them so late in the process as this could delay implementation.

Yours, Bill

William V. Little

Vice President, Vermont/New Hampshire

MVP Health Care

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Fletcher Allen
HEALTH CARE
In alliance with
The University of Vermont

Via e-mail

Wednesday, October 23, 2013

Ms. Georgia Maheras
Vermont State Innovation Model
89 Main Street, Third Floor, City Center
Montpelier, VT 05620

Dear Ms. Maheras:

We are writing to provide Fletcher Allen's written comments on the Commercial and Medicaid ACO Shared Savings Measure Set as recommended by the ACO Measures Work Group. We understand that several of the areas discussed below are currently in flux. Rather than assume what may have changed since the October 16 presentation to the SIM Core Team, these comments are based on the original proposal.

Let us start by thanking all of the leaders representing the State agencies involved in this work, as well as all of the interested parties. We have a unique appreciation for the complexities associated with discussing and building consensus around performance measurement and improvement. That experience, along with the expertise within Fletcher Allen – particularly through the James M. Jeffords Institute for Quality and Operational Effectiveness – is what has led us to focus on the areas outlined below.

Fletcher Allen supports measures that meet several broad goals. We recommend that we:

- Use measures that are actionable
- Use measures that drive the improvement that we are looking for across our state
- Use measures that are easily validated and do not require extensive chart review
- Pick a number of measures that is manageable
- Do not change the measures or add new additional measures for at least 36 months
- Focus the measures on improving the health of our population

We endorse the broadly accepted view that there is no "magic number" of measures. We suggest that the final set of measures adopted at this stage of the process provide an overview of the system's performance, allow for ACOs to focus on areas of improvement, and are manageable in number so that any provider organization can focus on them to drive positive change.

Using these guiding principles, Fletcher Allen recommends that the following measures be included in a "pay for reporting" system, and that the individual metric data associated with them not be used for determining achievement in the shared savings formula – outside of the act of reporting them – until the ramp-up of these measures is reasonably accomplished across the provider network in Vermont.

Measure Description	Rationale
Depression screening by 18 years of age	When determining performance in a specific year, a multiyear measure is not well suited for an annual measurement period. The historical claims data has not been validated as being representative of the true support of this objective by providers. We are concerned that this metric may result in unnecessary depression screening annually to meet the standard rather than enhancing timely depression screening in the pediatric population.
Developmental screening in first 3 years of life	This is a multiyear metric with limited time span look back (3 years), inconsistencies in billing practices warrants baseline claims validation before confidence in the metric is appropriate for payment. With appropriate emphasis on this metric in a reporting mode, the provider community will have specific feedback to improve the consistency of the claims basis that will ultimately allow for more direct payment use in a validated and collaborative manner to achieve the desired pediatric outcomes.
Chlamydia screening in women	While this is a measure with a long history, its validity as a measure based on claims data has not been strong. The biggest obstacle to face validity is that claims data, even with comparative logic applied to a variety of claims activity, still requires chart review to determine sexual activity before determining compliance with the measure.,
Avoidance of antibiotic treatment for adults with acute bronchitis	There are clinical conditions that influence the validity of *not* prescribing an antibiotic that would not necessarily be reflected in a claims source. Claims record what was done rather than the clinical decisions determined to avoid antibiotic use. Claims information may be incomplete, which would lead to validation by chart review for relevant medical factors in order to determine the face validity and appropriateness for this measure having an economic impact on providers directly. Refinement of this measure through results reporting and focus would be beneficial to both the providers and health care reform efforts.
Initiation and engagement of alcohol and other drug dependence treatment	Claim information may be incomplete, which would lead to chart review for relevant medical factors used to determine an appropriate course of follow-up. Review of this metric as reporting only with a review of patterns of provider action by selected chart validation reviews may be required to establish an appropriate level of confidence to warrant direct economic impacts through the payment mechanisms.
Follow-up after hospitalization for mental illness (7 day)	The worthwhile goal of this metric is often overshadowed by the shortfalls in the mental health provider resources available to providers. Using this metric in a reporting mode to assist in identifying the true impact and patterns of provider resource gaps in the mental health system rather than gauging provider performance on a metric that is too dependent on an already limited mental health provider capacity in the state does not appear to be in the best interest of any of the stakeholders. Reporting use of this metric could become a valuable tool for informing health policy decisions as well as for use in the development of provider performance evaluations.

We believe that consistency and the ability to develop robust and reliable benchmarks will be what matters most for evaluating all of the measures (whether they are issued by CMS or through this process). Therefore, we request that no new measures be added or any existing measures be eliminated for 36 months. The establishment of a stable measure set for 36 months will allow the Green Mountain Care Board, the SIM Core Team, and all of the primary stakeholders supporting this health care reform initiative to collaborate, enhance the clinical data infrastructures, and educate providers about the value of these metrics in guiding decision-making.

The importance of these metrics points to the need for improvements in health care delivery, as well as an increased focus on specific outcomes, all of which we strongly endorse. We are recommending the changes above to make the metrics more viable and reliable rather than recommending that they be dropped from consideration. We fully support the need to have a diverse and balanced range of metrics beyond the 33 measures issued by CMS for the Medicare Shared Savings Program.

Finally, related to the discussion of the measures, we are committed to engaging in a conversation about amending the existing primary care patient survey that we are using. We believe there is a solution that will satisfy all of our needs around gathering patient satisfaction data without causing unnecessary system or operational issues.

Please feel free to contact us to discuss these comments further.

Sincerely,

Stephen M. Leffler, MD
Chief Medical Officer

Howard M. Schapiro, MD
Interim President, UVM Medical Group

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October 22, 2013

Anya Rader Wallack
Core Team Chair
Vermont Health Care Innovation Project
89 Main Street
Montpelier, VT 05620

Re: Comments on ACO Measure Set

Dear Anya:

Thank you for the opportunity to comment on the proposed Accountable Care Organization (ACO) measure set and standards. Our comments will focus primarily on the importance of fostering a strong consumer focus in the ACO model, which includes ensuring that health care quality improves at the same time that shared savings are earned.

The Health Care Ombudsman and Vermont Legal Aid have participated in the Green Mountain Care Board's working group on quality measures since January, and more recently also attended the payment models workgroup. We are grateful that the governance standards were amended to foster transparency and include consumers in the governance of ACOs.

The working group process has been long and thorough. Still, some issues have yet to be addressed by the working groups, and so recommendations have not yet been submitted to the Steering Committee or the Core Team for consideration (e.g., the impact of Reporting measures on shared savings, and the process for modifying the measures set during the demonstration period). The demonstration's proposed measure set is the result of compromises by all stakeholders, and we believe that the current standards and measures take important first steps to improve quality of care. We write to lay out our ongoing concerns.

I. The Payment Measures subset of Core Measures is too small to effectively measure overall quality or to provide consumer protection over the three-year demonstration period.

In the first year of the demonstration, the ability of ACOs to earn shared savings is currently recommended to be based upon a mere seven to nine Payment measures. In contrast, the Medicare Shared Savings Program has thirty-three measures, which were reporting-only for the first year, but almost all of which will be required for payment for the ACOs in Vermont in 2014 when two ACOs will be in at least their second year. We recognize that there are technological limits and administrative burdens to including measures. As a result of those concerns, the Payment subset of the Core Measures was significantly limited. However, we are concerned that the scope may be too small given the broad spectrum of populations that will be served under this demonstration.

Quality measures allow the Core Team and the Green Mountain Care Board to assess whether ACOs have improved the care provided to attributed beneficiaries. We are concerned that with so few Payment measures, improved quality in these few areas may not be reflective of the level of care provided to all ACO patients. This is especially a concern because the Payment Measures subset does not include any measures in the domains of Patient Experience, Pregnant Women, Elderly & Disabled or End of Life Care. Further, while some stakeholders have suggested the measures should focus on care for people with chronic conditions, we believe that it is also important for the Payment measures set to include quality measures that ensure excellent preventive care.

In addition, quality measures are one of the only ways to protect consumers against providers taking to under-serving as a means of achieving savings. Payment tied to high quality performance serves as a counterbalance against such an approach. A Core Measures set with fewer than ten Payment measures, risks severely diminishing the effectiveness of that counterbalance. Although the quality measures working group used eleven different criteria to select measures, there was, in our view, an over-emphasis on the criteria that measures "not be administratively burdensome." This occurred both in the selection of measures and in the process for deciding whether to recommend a measure for the Payment, Reporting, or Pending subsets. The reality is that ACO participation is voluntary, and some administrative burden is necessary in order for ACOs to be *accountable* to their patients and to the Green Mountain Care Board's triple aim of improving quality of care, improving population health, and reducing health care costs.

Therefore, we recommend the Core Team dedicate significant resources to improving the collection and transferability of measures-related information. This would allow for expansion of the Payment measures subset, and better quality monitoring with less burden to providers, in years two and three of the demonstration.

II. The Core Measures set must be expandable throughout the demonstration period.

Through most of the measures selection process, the working group operated with an understanding that measures were being selected for the first year of the demonstration, and additional measures could be added in the future. Medicaid also determined that Medicare-Medicaid Dual Eligible beneficiaries would not be included in the Medicaid ACO population for year one. As a result, there was general agreement to table the search for (much less the selection of) measures to assess the quality of care for Duals, such as long term services and supports (LTSS) measures, even though a large percentage of LTSS beneficiaries are Medicaid-only. This was acceptable, but only because we believed that such measures could be added when the Duals moved into Medicaid ACOs in the second year of the Medicaid SSP demonstration. We believe that measures for LTSS are especially important because there are great opportunities for improving care coordination and quality and thereby reducing acute care costs for this vulnerable population. However, because beneficiaries of LTSS can be especially vulnerable, quality measures are imperative to protect consumers against changes that reduce cost without also improving quality.

It was only near the end of the process that other stakeholders raised concerns about the possibility that the measures set would change from year to year, creating uncertainty for providers. We recognize that providers participating in ACOs need some stability. However, without the ability to add measures to the Core Measures set, there will be a gaping hole with regard to LTSS for Medicaid, in particular. This would be inconsistent with the first criterion for measure selection – that measures be "representative of array of services provided and beneficiaries served by ACOs." Thus, we strongly support clear language in the Process for Review and Modification of Measures Standard to provide for the addition of new measures to the Core set to include LTSS in years 2 and 3.

We strongly believe that the Process for Review and Modification of Measures Standard must provide for the opportunity to expand the Payment and Measures reporting sets as baseline data becomes available and IT solutions reduce the administrative burden of reporting clinical measures. The measures work group identified all of the Core Measures (whether currently identified as for Payment, Reporting, or Pending) as measuring important information for which ACO providers should be held accountable. Thus, when feasible, measures in the Reporting and Pending categories should be promoted to Payment, and providers should be on notice, based on their inclusion in the Core Measures set, of that eventuality.

III. The overall size of the Core Measures set is not too large.

We are aware that some Steering Committee members believe that the Core Measures set is too large and onerous for providers. We strenuously disagree. There may be too few measures to adequately monitor the scope of care provided to specific populations.

In total, the Payment and Reporting measures subsets include at most 33 measures, the exact same number as the Medicare SSP measure set. This is true, even though Medicare's SSP targets only elderly and disabled populations. Medicaid and Commercial ACOs will encompass a much broader spectrum of Vermonters, and more measures are needed to assess the quality of care provided to all those served by the ACOs.

For example, the only pediatric measure in the commercial Payment set is "Adolescent Well-Care Visit" (Medicaid does also include Developmental Screening in the First Three Years of Life). There are two additional pediatric measures in the Reporting subset. That means however, that there are a grand total of three to four pediatric measures, which can be described, at best, as minimal in terms of ensuring quality pediatric care. We would support including the two Medicaid pediatric measures for the commercial population. Also of concern, there are neither Payment nor Reporting measures targeted to pregnant women, and the only women's health Payment or Reporting measures at all are for Chlamydia Screening and Breast Cancer screening.

Moreover, it is unclear what role the Reporting Measures will play in the calculation of shared savings, if any. Several proposals currently under consideration by the newly reconstituted Quality and Performance Measures Work Group would allow ACOs to avoid collecting and reporting on at least some percentage of Reporting measures. These types of gaps in reporting should be kept to a minimum. The ACOs should be required to report all of the Reporting Measures unless they can demonstrate extraordinary circumstances that make it impossible for them to do so.

While there are also measures in the Pending category, none of these will produce any administrative burden for ACOs in the first year because there is no reporting requirement. Even if these measures do move into the Payment or Reporting subsets, those changes will be examined with the same sort of careful, collaborative, effort that went into measure selection in the first place, including a high awareness of the burden to the providers.

IV. The Core Team should demand high quality before allowing an ACO to qualify for shared savings payments.

The proposed "gate and ladder" methodology would allow ACOs to earn points for meeting just the national 25th percentile. Vermont's ACOs should not get credit for doing far worse than the national average. Adopting this methodology would not create sufficient incentive for ACOs to improve care. We are also concerned with the plan to use national, rather than regional, benchmarking data, because the national benchmarks are lower than the regional ones.

In order to achieve the "improving care" element of the triple aim, we recommend that the Core Team apply the regional benchmarks. We recommend that ACOs not earn any points until they

reach at least the 50th percentile (and thus earn 1, 2, or 3 points at the regional 50th, 75th, and 90th percentiles). Based on the proxy Bailit Health Purchasing used to demonstrate how these benchmarks would likely play out in terms of the ability to earn savings based on current practice, this is necessary in order to ensure that care *improves*, rather than just maintaining current quality levels. We were surprised to hear that, at the end of the work group process, many stakeholders suggested that the goal of the ACOs should be to maintain rather than improve quality of care, at least in the first year. Using benchmarks which will require improvement, beginning in the first year, to earn savings is also in line with the intent of the measures working group, which assessed opportunity for improvement based upon the 90th percentile benchmark.

Finally, we are troubled by the possibility that an ACO could earn any shared savings by earning only 55% (commercial) or 35% (Medicaid) of possible quality points. The Core Team should not allow shared savings payments for performance that is, in almost any other context, considered failing; to do so would undermines the importance of providing high quality care.

The driving goal of an ACO should not be to earn the maximum possible savings in the first year, if the only way to do so is by setting the bar low. That is not consistent with the purpose of the ACO model, the SIM grant, and Vermont's overall health care reform goals.

Sincerely,

Trinka Kerr
State Health Care Ombudsman
VHCIP Steering Committee

TK/rs

From:	Wallack, Anya
To:	Maheras, Georgia
Cc:	Slusky, Richard; Suter, Kara; Jones, Pat
Subject:	Please add the to comments on proposed ACO measures. Thanks.
Date:	Wednesday, October 23, 2013 11:22:26 AM

TO: SIM Core Team
FROM: Paul Reiss, MD Medical Director, Accountable Care Coalition of the Green Mountains; Board Chair, Healthfirst
RE: Comments on proposed Commercial and Medicaid ACO measures.
DATE: October 22, 2013

The Medicare MSSP ACO program in which we participate has requirements that we report on 33 measures. After one round of reporting we find this to be an arduous and resource intensive task. The completed first round was for reporting only, but this year we are focused on the measure results, and are implementing widespread practice changes in approaching the measured conditions to ensure that that we reach benchmarks on the 19 measures that will be used to adjust shared savings, if there are any. As noted so well by Paul Harrington, EVP of the VMS, the attention to improving and reporting these quality metrics is an enormous burden on practices, and comes on the heels of other taxing programs that practices have had imposed. We note additionally that the MSSP and the proposed SIM ACO programs come with absolutely no funding for practices to carry on ACO required measurement and reporting activities, nor are there any guarantees that there will be eventual savings.

The amount of administrative work, in large part related to the measurement, reporting, and addressing of these measures, is a principal reason that we have chosen not to participate in the Medicaid shared saving pilot. The other major reason is that benchmarks are based on attributed patient past expenditures, rather than on severity adjusted average expenditures, and therefore the prospect of eventual savings is greatly diminished for networks like ours where we may already be practicing in a conservative manner. The more measures, the higher the risk of failure to recoup the significant resources invested in the programs.

We are in agreement in choosing claims based measures that are less onerous to report, but we are concerned that the measures selected are not necessarily the most important clinical issues to address, and therefore will receive an inappropriate excess force of attention, drawing resources away from more meaningful clinical matters.

As one the few clinical voices who was able to provide input on these matters, it was clear that additional clinical discussion was in order. The clinical utility of these measures should be the foremost determinant in prioritization. This would require expert clinical insight into the chosen measures before they are accepted. We recommend that such a process be applied, but to a much smaller number of measures.

Healthfirst makes recommendations in line with the recently expressed recommendations of Paul Harrington on behalf of the VMS:

A limited number of maternity and pediatric measures should be added to the MSSP measures, for both the Commercial and Medicaid pilots, and the full set of measures be used for the three years of the program. These pediatric and maternity measures should be vetted by experts in maternal and child health as important to common clinical outcomes, and easy

to measure. The list of "for reporting only" measures should be substantially reduced.

Additionally, each unique measure in these SIM ACO programs should be accompanied by reasonably accurate descriptions of the financial resources needed to retrieve and report the data; and furthermore, the responsibility for funding the collection and reporting should rest with the SIM program / Insurers themselves, not with the providers.

Attention to these recommendations would allow limited physician resources to be focused on the broad changes needed in clinical care processes for success of these SIM pilot programs.

Thank you for your attention to these concerns.

Paul J. Reiss MD FAAFP

Chair, Board of Directors, Health*first*
Medical Director, Accountable Care Coalition of the Green Mountains
802-343-1036 (cell)
802- 878-1008 x201 (office)

Anya Rader Wallack, Ph.D.
Chair
Vermont State Innovation Model (SIM) Core Team

From: Elizabeth Davis
To: Maheras, Georgia
Subject: SIMS Steering committee
Date: Wednesday, October 23, 2013 8:37:43 PM

Hello Georgia,

I realize I have not met today's close of business deadline re response to the ACO Shared Savings
Measure Set, but thought I'd send this on anyway--I had mentioned this to Pat Jones at the meeting:
The Medicare Claims data base shows whether a memory screen has been done for persons over the age of 65 since this is now a reimbursable expense for PCPs. I assume the Medicaid Claims data base does the same.

With the increase in the over 65 population and considering the fact that early diagnosis and
treatment can delay cognitive decline, it seems important to encourage PCPs to have memory
screens as part of their yearly wellness visit and collecting the data would therefore be useful.

Thanks,

Betsy Davis, RN,MPH

From: Bob Bick
To: Maheras, Georgia
Subject: Commercial and Medicaid ACO Shared Savings Measure Sets Feedback
Date: Friday, October 18, 2013 4:06:19 PM

I am very cognizant of both the comments made at the last meeting when the issue of reporting measures was discussed as well as the feedback I get from my own staff when asked to track data elements.
That said, I was surprised that while there are measures for tobacco use screening, depression screening, and high blood pressure screening there does not appear to be a comparable screening expectation for alcohol & drug use. There is an "initiation and engagement measure" but if I understand that correctly, that would be for folks who somehow have already been identified and their compliance with engagement is being measured. If I misunderstand, please advise. If not, and given the known impact of untreated alcohol and/or drug abuse/dependence on healthcare costs I would suggest that a screening measure be expected.
As always, I would be pleased to discuss in more detail if that would be helpful.
Thanks for the opportunity to comment.
B.

AGENDA ITEM #4A

Use of Reporting Measures in Shared Savings Distribution Determination Options Analysis
November 4, 2013

Option	Strengths	Weaknesses
#1: The ACO must submit *all* reporting measures[1], completely and in a timely manner, to retain any savings. Failure to do so will result in a forfeiture of 20% of net savings after consideration of payment measure performance in Year 1, and 50% in Year 2.	• Strong incentive to report, consistent with Work Group intent that reporting be a requirement.	• ACO could forfeit some savings for failure to adequately report on one of seven measures.
#2: The ACO must submit *most* reporting measures (e.g., 5 of 7), completely and in a timely manner, to retain any savings. Failure to do so will result in a forfeiture of 20% of net savings after consideration of payment measure performance in Year 1, and 50% in Year 2.	• Affords ACO a margin for failure.	• Could result in an ACO choosing not to pursue two measures altogether.
#3: The ACO will receive 1 point for each measure it submits completely and in a timely manner.	• The implications for non-reporting are less threatening to the ACO with Option #1, and possibly Option #2.	• The idea of including the reporting measures in the algorithm was previously rejected by the ACO Standards Work Group.
#4: [NEW] The ACO must submit all reporting measures completely and in a timely manner. Measure results should be accompanied by an analysis of any barriers identified during the reporting process, and a plan to mitigate any barriers. Failure to report shall carry no consequences to the ACO in Year 1.	• Allows the ACO a year to focus on measure generation and reporting capacity building.	• Could result in no reported clinical data-based measures for Year 1.

[1] Includes clinical data-based measures only and not payer-generated or patient experience measures.

Option	Strengths	Weaknesses
#5: [NEW] The ACO must timely submit all reporting measures, using EHR-generated data for those measures for which a sufficient number of ACO EHRs (as of 1-1-14) capture the data elements needed to generate Medicaid and commercial-specific measures for: • providers to which at least 50%[2] of Medicaid ACO membership is attributed, and • providers to which at least 50%[3] of commercial ACO membership is attributed. For any reporting measures for which a sufficient number of ACO EHRs (as of 1-1-14) do not capture the data elements required for measure generation, the ACO shall to the GMCB a) submit the aggregate rates for the practices that were able to report, b) submit a written plan for EHR data capture and measure generation by 5-1-14, and c) provide sufficient documentation by 12-1-14 of the ACO's ability to accurately generate the measures for the 2015 calendar year. Failure to do any of the above will result in a forfeiture of 20% of net savings after consideration of payment measure performance in Year 1.	• Advances progress towards electronic reporting of ACO clinical data-based measures. • Eliminates administrative and financial burden that would result from chart reviews.	• Is unlikely to produce performance information for all seven reporting measures in Year 1 as was intended by the former ACO Measures Work Group.

"Completely": ACOs shall have two options for reporting each of the measures:

1) using a random sample[4] of 411 commercially insured patients and 411 Medicaid patients, or
2) using EHR-generated data for the entire Medicaid measure-eligible patient population for providers representing at least 50%[5] of Medicaid ACO membership and for the entire commercial measure-eligible patient population for providers representing at least 50% of commercial ACO membership.

"Timely": by a GMCB-defined submission due date

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[2] Percentage proposed to increase in subsequent years.

[3] Percentage proposed to increase in subsequent years.

[4] Three options for sample generation: ACOs, payers individually, and payers collectively via GMCB's analytics contractor.

[5] Percentage proposed to increase in subsequent years.

AGENDA ITEM 4B

Comparison of Proposed 2014 ACO Reporting or Payment Measures for MSSP (Medicare ACO), Vermont Commercial ACO, and Vermont Medicaid ACO

Key: Y=Yes; N=No; C=Claims; MR=Medical Record; S=Survey; R=Reporting; P=Payment

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use Proposed 2014	Medicaid ACO Use Proposed 2014
Y	Risk-Standardized All Condition Readmission	C	R		
Y	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	C	P	R	R
Y	Ambulatory Sensitive Conditions Admissions: Heart Failure	C	P		
Y	% of PCPs who Successfully Qualify for an EHR Program Incentive Payment	Other	P		
Y	Medication Reconciliation	MR	P		
Y	Falls: Screening for Future Fall Risk	MR	P		
Y	Influenza Immunization	MR	P		
Y	Pneumococcal Vaccination for Patients 65 and Older	MR	P		
Y	Adult BMI Screening and Follow-Up	MR	P	R	R
Y	Tobacco Use: Screening and Cessation Intervention	MR	P		
Y	Screening for Clinical Depression and Follow-Up Plan	MR	P	R	R
Y	Colorectal Cancer Screening	MR	R	R	R
Y	Breast Cancer Screening	C	R	R	R
Y	Screening for High Blood Pressure and Follow-Up Documented	MR	R		
Y	Diabetes Composite (HbA1c control)	MR	P	R	R
Y	Diabetes Composite (LDL Control)	MR	P	R	R
Y	Diabetes Composite (High Blood Pressure Control)	MR	P	R	R
Y	Diabetes Composite (Tobacco Non Use)	MR	P	R	R
Y	Diabetes Composite (Daily Aspirin or Antiplatelet Medication)	MR	P	R	R
Y	Diabetes HbA1c poor control	MR	P	R	R
Y	Hypertension: Controlling High Blood Pressure	MR	P		
Y	IVD: Complete Lipid Panel and LDL Control	MR/C*	P	P*	P*
Y	IVD: Use of Aspirin or Another Antithrombotic	MR	P		
Y	Heart Failure: Beta Blocker Therapy for LVSD	MR	R		
Y	Coronary Artery Disease Composite (Lipid control)	MR	R		
Y	Coronary Artery Disease Composite (ACE or ARB for LVSD)	MR	R		

*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use Proposed 2014	Medicaid ACO Use Proposed 2014
N	All-Cause Readmission	C		P	P
N	Adolescent Well-Care Visit	C		P	P
N	Follow-Up After Hospitalization for Mental Illness (7 day)	C		P	P
N	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	C		P	P
N	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	C		P	P
N	Chlamydia Screening in Women	C		P	P
N	Developmental Screening in First 3 Years of Life	C			P
N	Depression Screening by 18 Years of Age	C			P
N	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	C		R	R
N	Appropriate Testing for Children With Pharyngitis	C		R	R
N	Childhood Immunization Status	MR		R	R
N	Pediatric Weight Assessment and Counseling	MR		R	R
	Patient Experience Surveys				
Y	NIS Patient Experience: Getting Timely Care, Appointments, Information	S	P		
Y	NIS Patient Experience: How Well Providers Communicate	S	P		
Y	NIS Patient Experience: Patients' Rating of Provider	S	P		
Y	NIS Patient Experience: Access to Specialists	S	P		
Y	NIS Patient Experience: Health Promotion and Education	S	P		
Y	NIS Patient Experience: Shared Decision Making	S	P		
Y	NIS Patient Experience: Health Status/Functional Status	S	R		
N	PCMH Patient Experience: Access to Care	S		R	R
N	PCMH Patient Experience: Communication	S		R	R
N	PCMH Patient Experience: Shared Decision-Making	S		R	R
N	PCMH Patient Experience: Self-Management Support	S		R	R
N	PCMH Patient Experience: Comprehensiveness	S		R	R
N	PCMH Patient Experience: Office Staff	S		R	R
N	PCMH Patient Experience: Information	S		R	R
N	PCMH Patient Experience: Coordination of Care	S		R	R
N	PCMH Patient Experience: Specialist Care	S		R	R
	Total Measures for Payment or Reporting 2014		33	31	33

*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.

AGENDA ITEM #5

Joint ACO Measures and Standards Work Group
Process for Review and Modification of Measures Standard
October 9~~18~~, 2013 Revised Draft

Standard:

1. The SIM Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set at the beginning of the third quarter of each pilot year, with input from the SIM Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes. In the interest of ~~maintaining the stability~~retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, ~~of the measure set, the Year 1 Payment and Reporting measures will~~ should not be ~~modified~~ removed ~~for Year 2~~in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The SIM Quality and Performance Measures Work Group and the SIM Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes at the beginning of the third quarter of each pilot year when NCQA publishes its Quality Compass product. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes.

3. The SIM Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set beginning in the first quarter of each pilot year, with input from the SIM Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If ~~during the review,~~ the SIM Quality and Performance Measures Work Group determines that a measure has the support of the Work Group and is ready to be ~~implemented~~advanced from Pending status to Payment or Reporting status in the next pilot year, it shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure. If the

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Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national benchmarks. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes.

4. The SIM Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** during the third quarter of each year after NCQA publishes its Quality Compass product, with input from the SIM Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the SIM Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than November 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications for the next pilot year by no later than** November 30~~th~~th. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the SIM Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the SIM Payment Models Work Group. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

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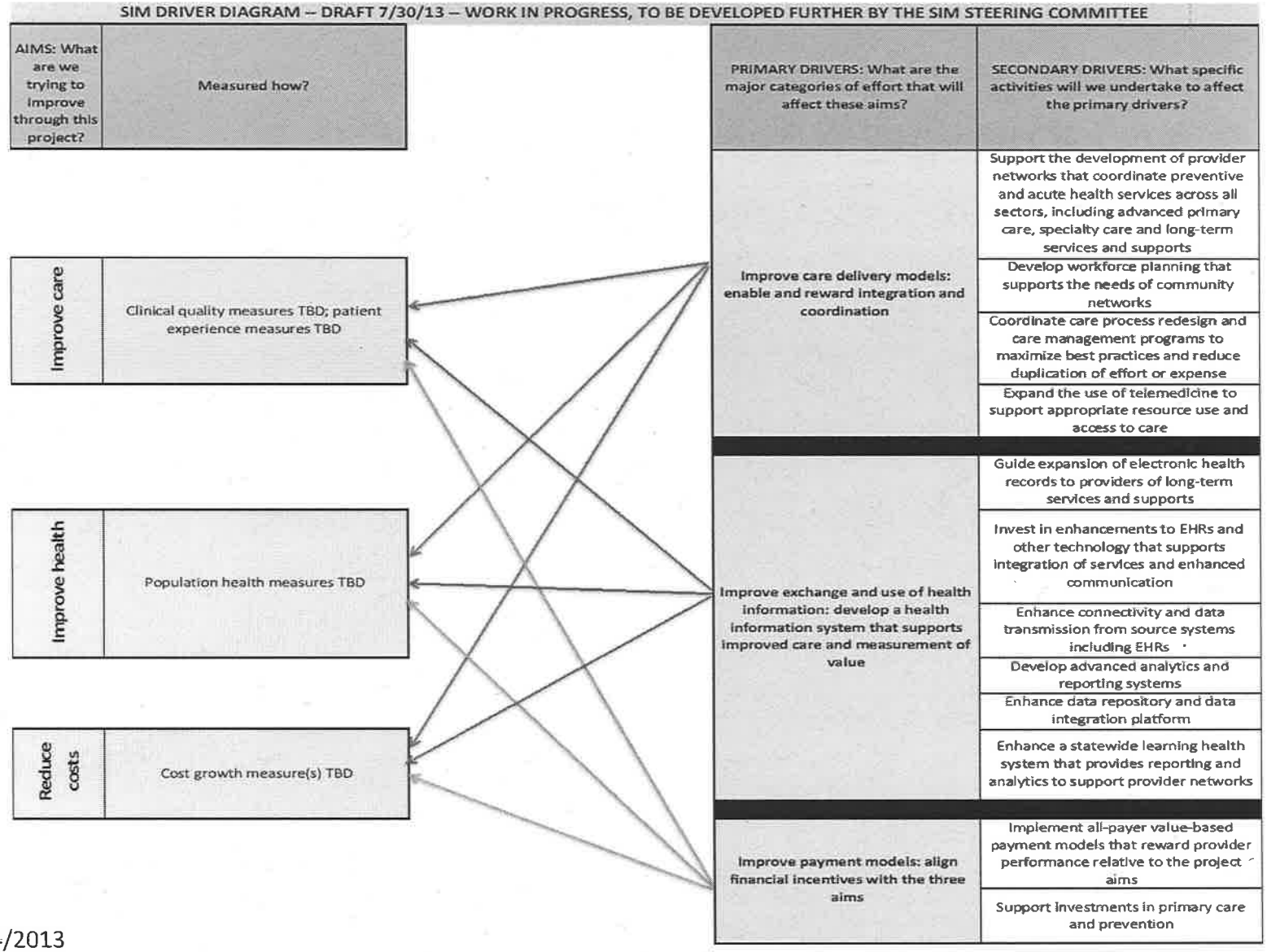
DRAFT-Vermont driver diagram



Agenda Item #6B

DRAFT-- 9-26-13

Proposed Measurement Strategy for Vermont SIM Driver Diagram
(Based on Recommended Year 1 Commercial/Medicaid Payment and Reporting Measures)

Vermont SIM Aim #1 -- Improved Care:

Patient Experience (9 Composite Measures) – Access to Care, Communication, Shared Decision-Making, Self-Management Support, Comprehensiveness, Office Staff, Information, Coordination of Care, Specialist Care

- ***By 2017, Vermont will achieve statistically significant improvement in at least 3 patient experience composites for attributed ACO shared savings members, attributed PCMH members, or both.***

Mental Health and Substance Abuse Treatment Process of Care (4 Measures) – Follow-up After Hospitalization for Mental Illness, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Adult Depression Screening and Follow-Up, Depression Screening by 18 Years of Age

- ***By 2017, Vermont will achieve statistically significant improvement in at least 2 mental health and substance abuse process of care measures at the ACO, PCMH, health plan and/or state level.***

Adult Process of Care (5 Measures) – Adult Weight (BMI) Screening and Follow-Up, Colorectal Cancer Screening, Mammography/Breast Cancer Screening, Chlamydia Screening in Women, Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis

- ***By 2017, Vermont will achieve statistically significant improvement in at least 2 adult process of care measures at the ACO, PCMH, health plan and/or state level.***

Pediatric Process of Care (5 Measures) – Pediatric Weight Assessment and Counseling, Childhood Immunization Status, Adolescent Well-Care Visits, Developmental Screening in the First Three Years of Life, Appropriate Testing for Children with Pharyngitis

- ***By 2017, Vermont will achieve statistically significant improvement in at least 2 pediatric process of care measures at the ACO, PCMH, health plan and/or state level.***

Vermont SIM Aim #2 -- Improved Health:

Chronic Disease Outcome Measures (3 Measures) – Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only); Diabetes: Hemoglobin A1c Poor Control; Diabetes Composite (Hemoglobin A1c Control, LDL Control, Blood Pressure Control, Tobacco Non-Use, Aspirin Use)

- ***By 2017, Vermont will achieve statistically significant improvement in at least 1 chronic disease outcome measure at the ACO, PCMH, health plan, and/or state level.***

- ***See also Process of Care Measures under Aim #1 (Improved Care).***

Vermont SIM Aim #3 -- Reduced Costs:

Hospital Admission or Readmission Measures (3 Measures) – All-Cause Readmission, Ambulatory Care-Sensitive Conditions Admissions (COPD), Rate of Hospitalization for Ambulatory Care-Sensitive Conditions (PQI Composite)

- ***By 2017, Vermont will achieve statistically significant improvement in at least 1 hospital admission or readmission measure at the ACO, PCMH, health plan and/or state level.***

Total Cost of Care Measures (2 Measures) – Total Cost of Care (Total Cost Index), Total Cost of Care (Resource Use Index)

- ***By 2017, Vermont will achieve statistically significant improvement in at least 1 total cost of care measure at the ACO, PCMH, health plan and/or state level.***

AGENDA ITEM #7

Proposed Meeting Schedule for the Vermont Health Care Innovation Project
Quality and Performance Measures Work Group
December 2013-December 2014

December 12, 2013 10AM-12PM

January 20, 2014 10AM-12PM

February 17, 2014 10AM-12PM

March 17, 2014 10AM-12PM

April 21, 2014 10AM-12PM

May 19, 2014 10AM-12PM

June 16, 2014 10AM-12PM

July 21, 2014 10AM-12PM

August 18, 2014 10AM-12PM

September 15, 2014 10AM-12PM

October 20, 2014 10AM-12PM

November 17, 2014 10AM-12PM

December 15, 2014 10AM-12PM